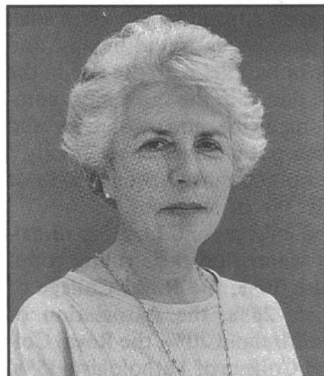
Second among equals

LOTTE NEWMAN



Introduction

JAMES MACKENZIE will perhaps be best remembered for his work concerning the heart and circulatory system; an interest which generated several books and invaluable research. Ironically, he himself suffered a weak heart, enduring many years of angina until it finally claimed his life in January 1925. Strangely enough I was invited to give this lecture on the day following an angiogram which led me to have cardiac surgery. I felt especially fortunate as I had benefited from medical advances based on the work Mackenzie had begun.

On reading about Mackenzie's life, I was struck by the important role played in it by women. His interest in cardiology was sparked off by a woman who died in childbirth from heart failure. His deep concern for the working women of Burnley, prompted him to write a Dickensian style novel called *Mary Helm.*[1] I have consequently chosen as my subject women — their health, and as patients and general practitioners. Sadly, women are still second among equals in general practice today.

Women's health

The majority of women in Mackenzie's day spent most of their lives and almost all of their energy in an endless cycle of childbirth and childrearing. High levels of maternal mortality (five per 1000) arose from poor living and working conditions. Medical care was either expensive or risky. Education was a privilege, and notions such as ambition, equality of opportunity and personal fulfilment were pipedreams for the 19th century working mother.

The 20th century has brought about a revolution in women's health. We have been emancipated in the sense that we are no longer victims of the 'curses of our sex'. Maternal deaths are less than one in a 1000 and risks in obstetrics and standards of care are now assessed by reference to the perinatal mortality rate. In September 1991 the perinatal and infant mortality rates fell to the lowest level recorded in England and Wales — 8.1 per 1000 total births and 7.9 per 1000 live births, respectively (Office of Population Censuses and Surveys). The range of contraceptives available means that women can now limit the number of children that they have and space their families to suit their careers and health needs.

Following the abortion act of 1967, women gained access to safe abortion. Given the estimated 20 million abortions a year in Europe, the consequences of denying access to safe abortions are unthinkable.[2] The advent of the controversial abortion inducing drug RU486 (Mifepristone, Mifegyne) in the United Kingdom in 1991, offered women the opportunity for non-surgical abortion; an option that has already been safely taken by 100 000 women worldwide.

In 1988 we saw the introduction of the National Health Service Breast Screening Programme. Although controversy surrounds this programme, I believe it offers an opportunity to reduce mortality from a major killer. The importance of teamwork in this programme must not be underestimated. General practitioners have a central role to provide information and to encourage patients to take part in the programme; this may be particularly relevant following the recent controversy in the media about breast self examination following the statement by the chief medical officer that women should stop checking their breasts. The Department of Health has now given the advice that women should be 'aware' of their breasts, while the Committee on Breast Cancer Screening has verified that 'at present over 90% of breast cancers are found by women themselves' (Department of Health, press release H91/453). As breast screening is only offered to women aged 50–64 years, women should be encouraged to do everything they can to reduce mortality from breast cancer.

General practitioners are making significant contributions to cervical screening programmes. Department of Health figures for October 1990 indicate that in three quarters of the health districts in England, at least 85% of practices had achieved either the 50% or 80% target. However, perhaps our target should be to achieve the success enjoyed in Finland where screening has been available for the last 15 years with nearly 100% coverage of the relevant population (Kiuru E, personal communication).

Another major factor in the physical emancipation of women has been the introduction of hormone replacement therapy. This therapy has meant relief from physical and emotional distress for thousands of menopausal women and has been an effective treatment in the prevention of osteoporosis. The possible link between long-term use of hormone replacement therapy and breast cancer has been investigated in a large scale trial carried out by Hunt and colleagues in Oxford.[3] They examined breast cancer mortality in more than 4500 long-term users of hormone replacement therapy, and concluded that in the final analysis any risk of breast cancer must be considered in relation to other aspects of the therapy. Hostility to hormone replacement therapy is a peculiarly British problem: currently only 8% of post-menopausal women in the UK are taking the therapy and many of these for a brief period only.[4] Women should be encouraged to take hormone replacement therapy. Today, the average life expectancy for women is 80 years; in Mackenzie's day it was 50 years. Thus, many women in the western world spend a third of their lives in their post-menopausal years. Hormone replacement therapy can improve the quality of that life.

In spite of these dramatic advances, women are the greatest consumers of health care. Women's importance in the health system was emphasized by the publication of the booklet, *Your health: a guide to services for women.*[5] Equally significant has

L Newman, OBE, BSc, FRCGP, general practitioner, London. The text is based on the 1991 James Mackenzie lecture which was delivered at the annual general meeting of the Royal College of General Practitioners held on 16 November 1991.

© *British Journal of General Practice,* 1992, **42**, 71-74.

been the rise of consumerism over the last 20 years, exemplified by the formation of the Patients' Association and a growing assertiveness among women patients. Women frequent general practitioners' surgeries more than men because of problems unique to them. They also accompany young, old and handicapped people, or even attend on their behalf. In addition, there are more women in the older age groups: almost two thirds of the over 65 years age group are women, and among over 85 year olds women outnumber men by three to one (OPCS, Population Estimates Unit, 1990).

Worryingly, women are also disproportionately represented in the mental health statistics. The 1981–82 national morbidity survey, of over 300 000 people, identified different consultation rates in the two sexes, for anxiety and depression.[6] The survey found twice as many women as men diagnosed with anxiety, and three times as many with depression. It is hard to say whether this sex disparity is a 20th century disease, a sex difference or due to the perceptions and sex of the women's general practitioners.

Women as patients

As a significant proportion of consultations are prompted by obstetric or gynaecological needs, it is hardly surprising that women prefer to consult women doctors. Cooke and Ronalds' study of Manchester general practitioners found that women were more likely to consult women doctors about a range of sex related conditions, particularly those of an 'embarrassing' nature.[7] British society is becoming multi-racial, so an increasing number of women patients may refuse, for religious or cultural reasons, to see a male doctor. The health of these women and their families may suffer seriously if there is no woman general practitioner that they can consult.

In 1990 Graffy found that more than half the women patients attending a south London practice preferred to see a woman general practitioner for specific problems, and nearly four out of 10 wanted to see another woman doctor on every visit to the surgery. The majority of men did not feel the doctor's sex mattered.[8] Figures for April 1991 reveal that in almost half the practices in England, that is, in 4386 partnerships, patients do not have access to a woman doctor (Press V, Department of Health, April 1991).

In their 1983 study Preston-Whyte and colleagues found that women doctors followed up their patients more often.[9] Women doctors might be more popular because their patients prefer the care they provide. These perceptions have been borne out in studies showing that women doctors tend to be less formal, dogmatic and domineering, and communicate more easily with patients, especially female patients, giving them more consultation time and less medication.[10]

The so-called feminine qualities of compassion, caring and sensitivity, are found in both sexes. How do we promote these characteristics in a profession with such dependence on scientific methods? We must look at medical education. Is there enough emphasis in training on the needs of patients?

Women as general practitioners

Since the sex discrimination act of 1975, the intake of women medical students has increased considerably. Over the period 1979–88 the proportion of applicants who were women rose by 10% (Universities Central Council on Admissions). In 1989 49% of the student intake were women (Livesey H, Economic Research Unit, BMA, personal communication). Equality of opportunity for entry into medicine is now a reality. There has been a similar trend in the ratio of women to men participating in general practitioner trainee schemes (Livesey H, personal communication).

The changes medicine must make to accommodate its new demography are overdue. By this I mean breaking through the 'glass ceiling', the invisible barrier to women's progress in the medical hierarchy. Women tend to rise so far and no further in certain specialties and particularly in the ruling bodies of medicine. The proportion of women consultants in areas such as mental health, pathology, paediatrics, radiotherapy and radiology, has increased roughly in parallel with the rise in the proportion of women graduates. Sadly, in the three most competitive specialties — surgery, medicine and obstetrics and gynaecology — the proportion has not changed substantially.[11] According to the latest figures, women make up only 15% of consultants in the UK, and only 3% of surgeons.[12]

A telephone survey of the royal colleges and faculties revealed the following percentages of women on their ruling councils: the Faculty of Public Health 30%, the Royal College of Obstetricians and Gynaecologists 26%, the Association of Anaesthetists of Great Britain and Ireland 20%, the Royal College of Physicians 17%, the Royal College of Pathologists 15%, the Royal College of General Practitioners 13% and the Royal College of Surgeons 4%.

In general practice, there are no women professors in any of the 29 departments in the UK. The Netherlands, Portugal and Germany, each have one female professor of general practice. I have written to many female colleagues around the world on this issue and received replies from as far afield as New Zealand and Guatemala. All followed a similar theme: the difficulty of combining motherhood and general practice. Women general practitioners are in great demand throughout the world, but as in the UK, are in short supply especially in rural areas.

Ironically, in the former Soviet Union and Eastern bloc countries where women doctors predominate, their status in the profession is low. This process was described by Helena Hovorova, a Czechoslovakian doctor, as the 'feminization of medicine' whereby women, particularly in general practice, have experienced less competition, outnumber men, but have a lower status (personal communication). Closer to home, in the RCGP, men have been awarded fellowships at seven times the rate of women.

An explanation for the shortage of women in the medical hierarchy is put forward by Judith Lorber in her book *Women physicians: careers, status and power:* people tend to choose successors in their own likeness.[13] Yet, some women overcome these barriers and are granted honorary manhood, especially those who demonstrate stereotypical male characteristics. Given that their role models are men, these women are unlikely to encourage female successors. They therefore tend to reinforce institutional sexism.

It is often suggested that women choose their biological role rather than their professional role. However, a woman's choice to devote her energies to her family rather than to her work may be the result rather than the cause of her diminished career opportunities. A women's marital status often works against her. If married she is considered committed to her family rather than her career, if unmarried she is thought to be a potential risk because a sexual relationship is considered her prime priority.

There is no evidence that a difference in the abilities of women and men accounts for women's scarcity in certain specialties or positions. In fact, women often achieve higher academic standards than men. For example, the pass rates for the MRCGP examination from May 1988 to May 1991 show that women candidates, who were outnumbered by three to two, gained proportionally twice as many distinctions as their male colleagues.

The present structure of medical training confronts women with an insoluble dilemma. The undergraduate and initial

postgraduate years coincide with their optimum reproductive period. Why should women have to choose between their biological and professional roles? The reluctance of the medical hierarchy to allow all junior training posts to be fully accredited on a part-time basis is indirect discrimination against women. Although part-time senior house officer training has been made available, at present less than 1% of senior house officers are working in part-time posts.[12]

Career difficulties for women doctors can also be attributed to the lack of child care facilities within the NHS. Out of an NHS staff of 1.1 million, 79% are women,[14] for whom the nursery provisions are woefully inadequate. Adequate maternity leave is also crucial if women are to have any hope of balancing their family and career commitments. A European Commission directive would increase maternity pay for British women. In November 1991, the British government finally agreed to accept a watered-down version of the original proposals, which will mean some improvement for working mothers. Matters with respect to maternity leave are also looking up for doctors as the result of a recent agreement between the British Medical Association and the Whitley council (the body which negotiates terms and conditions of service in the NHS) which will affect women with babies born on or after 8 January 1992.

Paternity leave is just as important as maternity leave, as more fathers want to spend quality time with their wives and families. Enabling women to share domestic duties and the burdens of bringing up a child with their husbands is crucial to their professional survival. A new agreement announced by the Department of Health in January 1991 goes some way to meeting this need. However, health authorities are left to determine the length of leave available and whether or not it should be paid.

NHS reforms

To understand the current position of women general practitioners, we must consider the changes brought about by the reforms to the NHS. The number of applicants for vocational trainee schemes has fallen substantially, and with many general practitioners reluctant to train in inner cities, vacancies remain unfilled. Although the number of unrestricted principals now exceeds 27 000, Department of Health figures for April 1991 show that the long-term rise in the number of unrestricted principals is coming to a halt. The number of vocational trainee certificates issued has also declined, but again there has been a noticeable increase in the number of female recipients (Joint Committee on Postgraduate Training for General Practice).

More general practitioners are now taking early retirement, some prompted by recent changes in the NHS. This was confirmed by a questionnaire survey carried out in the south west region which showed that many mature doctors are considering early retirement specifically to escape the new contract (Maxwell R, personal communication). Sadder still, many younger doctors are considering options outside medicine altogether. The effects of the new contract for general practitioners have not yet been fully analysed but early indications are that it has had a negative impact on the labour supply.

Prior to the introduction of the new contract the number of women general practitioners rose to over 6500 for the first time and there was an increasing awareness among men general practitioners that the presence of a woman doctor in the practice was advantageous. Frequently this need was overcome by employing a woman as a salaried 'partner', who had little say or pay, or as an assistant who had even less of either. Alternatively, a woman trainee was appointed annually so that a female face was seen in the practice, but rarely heard in its management. Although undesirable, these alternatives did give patients the opportunity to consult a woman doctor. Gradually though, an increasing number of women principals were appointed as partners, especially in larger group practices, where their popularity among patients was recognized.

However, since the introduction of the new contract the situation has deteriorated as practices are appointing fewer principals because of uncertainties with regard to workload and income. In addition, greater rigidity in the hours worked has discouraged the number of women applicants, especially as their prospective share of the profits may be far less than the time commitment expected.

One of the few positive changes brought about by the new contract is the automatic payment for a locum engaged during absences owing to pregnancy and childbirth. The allowances are no longer tied to list size criteria. However, in spite of the better position with regard to maternity leave, many women general practitioners have become disenchanted, prompting defections and mass resignations. Others have been pushed into single-handed practice feeling that they have been unfairly treated both by the health service and their former partners.

The intention behind the new arrangements for part-time work was to increase the numbers of women in general practice — but the effect has been the opposite. The doctor's retainer scheme is another initiative specifically designed to help women doctors, but unfortunately it too has fallen short of expectations. It was introduced to help those under the age of 55 years who are working for not more than one day a week to keep in touch with medicine. The majority of retainees work in general practice. The retainer has been increased to £290 per annum, which is subject to income tax. Retainees and assistants in general practice are now the only groups of doctors working within the NHS who pay their own defence fees; both groups are predominantly women. The restriction to working one day a week hinders a gradual return to full-time work and the restoration of skills and confidence. It should be possible for retained doctors to increase their hours gradually until it becomes more cost effective for the practice to employ them as an assistant or partner.

Positive trends

All is not doom and gloom, however. Some women have been spurred to action, while others are receiving recognition from their male peers.

Positive action has been taken by some women on the RCGP council (Molly McBride, Sarah Jarvis and Iona Heath), who together with Irene Weinreb, the Secretary of the Medical Women's Federation, formed a women's working group to identify the problems of young women general practitioners. In the under 30 years age group women outnumber men in the RCGP, but unfortunately this group also have the highest rate of leaving. In a bid to reverse this trend, the women's working group circulated a questionnaire to all young members and associates as it was felt that many of the problems identified by women doctors related to both sexes. There are plans to repeat this exercise among women doctors in the 30–45 years age group, who are returning to work after having raised a family. On the basis of information collected and the results of a workshop, the group suggested a woman's officer on council, telephone advisory services and databases, jobsharing opportunities in the faculties, and that the government should be lobbied to provide a postgraduate education allowance for assistants and women on retainer schemes.

On a further positive note, there has been some recognition of the role of women in general practice by their appointment to high office. Three of these appointments occurred during 1991. The first was Alison Hill who was appointed as the first woman chairman of the Conference of Local Medical Committees. She is a lecturer in the Department of Academic Medicine/General

Practice at the University of Southampton. Further history was made when Judy Gilley, a general practitioner from Barnet, was appointed as the first woman negotiator of the General Medical Services Committee. Jacky Hayden is currently the only woman regional advisor in general practice and works in the north of England. All three women are married with children.

It will be obvious when considering the lives of women who have achieved success in general practice that they have to be excellent organizers. The 'superwoman' factor still prevails: satisfying family needs and meeting professional goals requires sacrifice, stamina and a supportive spouse. Perhaps a competing medical spouse should be avoided.

No advocate of women's rights wants to see mediocre women promoted and admittedly, there are not enough qualified women today to have a one to one ratio at senior levels in all medical specialties. However, there will be in the next century if we act now to make rewarding careers attainable for women doctors.

'The sky is the limit' declared the prime minister, John Major, when he opened Opportunity 2000, a campaign to encourage companies to promote women. If these words go beyond a public relations exercise and practical moves such as tax relief on childcare expenses, better maternity leave, nursery provisions and pay equity are made, then perhaps the myth of equality for women in the UK may at last become a reality.

Women in medicine are not fighting a battle of the sexes, but for the health of our professional body and for the health of patients. We are not prepared to go on as second among equals. The days when women made good workhorses but not good partnership thoroughbreds are over.

I conclude with my own 10 commandments jointly addressed to the powers that be and to women general practitioners, the aim of which is to improve the lot of all patients and all general practitioners, and raise the standard of general practice.

1. Thou shalt broaden the education of all students entering medical school.
2. Thou shalt humanize undergraduate training.
3. Thou shalt make part-time training freely available to all senior house officers and trainees.
4. Thou shalt ensure greater flexibility of work for all principals.
5. Thou shalt choose thy life partner carefully.
6. Thou shalt carefully plan thy pregnancies.
7. Thou shalt provide better maternity and paternity leave.
8. Thou shalt have good off-duty and holiday relief.
9. Thou shalt be blessed with good physical and mental stamina.
10. Thou shalt be optimistic about the future of general practice.

References

1. Mair A. *Sir James Mackenzie MD 1853-1925. General practitioner.* London: Royal College of General Practitioners, 1986: 56-66.
2. O'Neill P. From abortion to contraception in Europe. *BMJ* 1990; **301:** 1011.
3. Hunt K, Vessey M, McPherson K. Mortality in a cohort of long-term users of hormone replacement therapy: an updated analysis. *Br J Obstet Gynaecol* 1990; **97:** 1080-1086.
4. Tindall G. Medicalizing the menopause: hormone replacement therapy — solution or problem? *J R Soc Med* 1991; **84:** 569.
5. Department of Health. *Your health: a guide to services for women. O/N 13916 (HSSH) J1299NJ.* London: DoH, 1991.
6. Royal College of General Practitioners, Office Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice. Third national study, 1981-82.* London: HMSO, 1986.
7. Cooke M, Ronalds C. Women doctors in urban general practice: the patients. *BMJ* 1985; **290:** 753-755.
8. Graffy J. Patient choice in a practice with men and women general practitioners. *Br J Gen Pract* 1990; **40:** 13-15.
9. Preston-Whyte ME, Fraser RC, Beckett JL. Effect of a principal's gender on consultation patterns. *J R Coll Gen Pract* 1983; **33:** 654-658.
10. Berthiaume M, Dufort F, Lambert J, Maheux B. Do female general practitioners have a distinctive type of medical practice? *Can Med Assoc J* 1988; **139:** 737-740.
11. Lefford F. Women doctors: a quarter-century track record. *Lancet* 1987; **1:** 1254-1256.
12. *Women doctors and their careers. Report of the joint working party.* London: Department of Health, 1991.
13. Lorber J. *Women physicians: careers, status and power.* New York: Tavistock Publications, 1984.
14. Equal Opportunities Commission. *Equality management: women's employment in the NHS.* London: Equal Opportunities Commission, 1991: 3.

Address for correspondence

Dr L Newman, The Surgery, 1 Cholmley Gardens, Mill Lane, London NW6 1AE.

College Publications
RESEARCH AND AUDIT

Epidemiology in Country Practice
William Pickles' own work — first published in 1939 — the classic example of original research in general practice. *'... an inspiration for us today'* New Zealand Family Physician. £5.50

Epidemiology and Research in a General Practice
Published posthumously, this book comprises 16 chapters of Dr Watson's unfinished work plus nine articles, mainly on the impact of virus diseases in general practice. £10.50

The Measurement of the Quality of General Practitioner Care (Occasional Paper 15)
A detailed review of the literature on quality of care. Essential reading for those trying to measure and promote quality in general practice. £3.00

Practice Activity Analysis (Occasional Paper 41)
Describes the results of practice activity analysis undertaken by the RCGP Birmingham Research Unit over a number of years and discusses its role as a practical approach to audit and assessment of quality. £6.50

Who Killed Susan Thompson? (Video)
Set in a fictional four doctor partnership in an English market town, this video demonstrates the link between individual clinical competence and medical audit. £30.00
(Additional Course Books £5.00)

All the above can be obtained from the Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU (Enquiries, Tel: 071-823 9698). Prices include postage. Cheques should be made payable to RCGP Enterprises Ltd. Access and Visa welcome (Tel: 071-225 3048, 24 hours).