

Why family medicine benefits from more women doctors

Now that entry into medical school has stabilised at around two women to every one male entrant, apparently based both on women's current academic track record and stronger achievements in empathy and relational aptitudes,¹ the debate about women in medicine has taken a new form: not that of the 19th century, when women were considered too fragile for the profession,² but of the 'too many doing too little' variety, which, ironically, has been attributed to one of our most prestigious contemporary female physicians.^{3,4}

General practice directly reflects both the rise in female doctors and an increase in part-time working in medicine, with 40% of the GP workforce in 2005 being women, of whom almost half were working part-time, compared to 12% of men.⁵ Two papers in this Journal^{6,7} confirm some differences in working practices between men and women, especially in terms of part-time practice (which, incidentally, continues to show a wide range of hours worked). Various concerns have been raised about the changing workforce picture, including loss of continuity due to increasing numbers of part-time staff,⁸ loss of perceived professional status (at least in the popular media⁹), and the problems of workforce planning when the lifetime career input of each doctor trained becomes less predictable.¹⁰ Whether the feminisation of the workforce is entirely to blame for these factors, however, probably depends more on the beliefs and prejudices of those expressing concern than on the balance of fact. Gender, after all, is not the same as sex: male and female is (usually) a biological fact, whereas the concept of gender relates to a complex set of social structures and cultural pressures that result in different outcomes for men and women doing the same job.¹¹

Many of the social and organisational changes in medical practice reflect contemporary beliefs and aspirations: some result from political interventions such as the new GMS contract, demand for constraints on professional autonomy and related public questioning of doctors' authority,¹² plus a

desire for doctors of both sexes to have a personal life and professional interests outside their clinical practice. Gravelle and Hole⁶ show interesting variations in actual hours and related practice characteristics, which they show cannot be entirely explained either by sex or family circumstances. While cross-sectional studies may show some differences in working patterns, there is no evidence that in a career lifetime women wish to do substantially less frontline clinical work than male colleagues;¹³ and in these days of the portfolio career, many doctors want to work part-time in practice in order to take up managerial, educational or other special interests.¹⁴ Papers, such as those in this Journal,^{6,7} tell us what is happening but give no insight into outcomes for patients or staff, and in this sense are very preliminary inputs to the debate about the feminisation of general practice.

There are some good reasons to celebrate the rise of women in family medicine. An increasing number of women actually want to be GPs at graduation,¹⁵ which must be better than having failed male specialists making up the bulk of the vocational training intake. Consultations with women doctors have been shown to be more patient centred and informative than with male physicians,¹⁶ and equally satisfactory for both male and female patients in primary care.¹⁷ Women are more likely to work with marginalised and vulnerable communities and to be a major source of clinical input to maternal and child health (a WHO and UN priority).¹⁸ The inclusion of women as equal partners in society is recognised as a key determinant of health and development by WHO, and more women in the work environment may increase emotional supportiveness, and team working for both staff and patients. However, it may be that we could get more out of our women doctors if residual prejudices and barriers did not continue to impede their performance and contribution.

Women doctors continue to succeed in their early careers, but figure much less in the senior roles of the profession.¹⁹ Their

more frequent experience of harassment by both staff and patients,²⁰ consistent disadvantage compared to male colleagues in terms and conditions,²¹ and a lack of both flexible training and working opportunities,²² means that many women are less able to work, and work with less satisfaction, than could be the case. Their tendency to form closer relationships and share emotional intimacy with their patients means an increased affective burden, which could put them at risk of burnout and depression, although role stress and dissatisfaction appears to be greater for men than women in some settings.²³ Women are also more likely than men to be negatively evaluated when using necessary professional coping mechanisms of being clear about lines of responsibility at work, saying no, and keeping tight boundaries.²⁴

The World Organisation of Family Doctors (Wonca) the umbrella organisation for colleges and academies of family practice, supports a specific working party (Wonca Working Party on Women and Family Medicine [www.womenandfamilymedicine.com]) which is dedicated to considering the work of women family physicians and how to maximise their effectiveness and value. The Working Party has existed since 2001, and draws together women family medicine practitioners from all continents to share problems and solutions, examining issues of equity for women doctors (rather than equality, which does not always recognise different societal needs and personal abilities). It works to support women family physicians across the world to build their capabilities as confident clinicians, leaders and educators, and also makes demands of organisations (including Wonca itself!) to secure equity of opportunity and representation for women at all levels. The existence of the Women's Working Party is paralleled within many other medical professional colleges worldwide, and the debate is not about whether women should be working in medicine, but about the nature of their contribution to high quality patient care. This is well summarised in the mission

statement of the Medical Women's International Association (www.mwia.net), whose goals are to:

- promote the cooperation of medical women in different countries;
- actively work against gender-related inequalities in the medical profession between female and male doctors including career opportunities and economical aspects;
- offer medical women the opportunity to meet to discuss questions concerning the health and well-being of humanity; and
- overcome gender-related differences in health and health care between women and men, between girl-child and boy-child throughout the world.

The Women's Working Party would query the 'macho' aspect that requires long hours of repetitive frontline clinical work without either career diversity or work-life balance. We argue that creating conditions that maximise all doctors' inputs at all stages of their careers, including family-friendly working practices and encouraging some outside interests for all clinicians, can address both under- and over-utilisation of doctors of both sexes. The gains we can make from the entrance of women into the medical workforce are not yet all realised, and there is a need to go beyond an argument about quantity into one about quality and best use of our human resources. The main characteristics affecting patient

care are more about how an organisation and individual clinicians respond to their needs than about gender or hours worked,²⁵ and a happy doctor of either sex is more likely to be effective than a disenchanted one.

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REFERENCES

1. Lumsden MA, Bore M, Millar K, *et al*. Assessment of personal qualities in relation to admission to medical school. *Med Educ* 2005; **39**(3): 258–265.
2. Burstyn J. Education and sex: the medical case against higher education for women in England, 1870–1900. *Proc Am Philos Soc* 1973; **117**(2): 79–89.
3. Royal College of Physicians. Briefing on Women in Medicine. http://www.rcplondon.ac.uk/college/statements/briefing_womenmed.asp (accessed 12 Jan 2007).
4. BBC. Women docs 'weakening' medicine. <http://news.bbc.co.uk/1/hi/health/3527184.stm> (accessed 16 Jan 2007).
5. Royal College of General Practitioners. Profile of UK general practitioners. http://www.rcgp.org.uk/pdf/ISS_INFO_01_JUL06.pdf (accessed 12 Jan 2007).
6. Gravelle H, Hole A. The work hours of general practitioners: survey of English GPs. *Br J Gen Pract* 2007; **57**: 96–100.
7. Rossdale M, Kemple T, Payne S, *et al*. An observational study of variation in general practitioners' out-of-hours emergency referrals. *Br J Gen Pract* 2007; **57**: 152–154.
8. Freeman G, Hjortdahl P. What future for continuity of care in general practice? *Br Med J* 1997; **314**: 1870–1873.
9. Phillips M. The kindness of strangers. <http://www.melaniephillips.com/articles-new/?m=200408> (accessed 12 Jan 2007).
10. Young R, Brenda Leese B, Sibbald B. Imbalances in the GP labour market in the UK: evidence from a postal survey and interviews with GP leavers. *Work Employment and Society* 2001; **15**: 699–719.
11. Riska E. Towards gender balance: but will women physicians have an impact on medicine? *Soc Sci Med* 2001; **52**(2): 179–187.
12. Light D, Levine S. The changing character of the medical profession: a theoretical overview. *Milbank Q* 1988; **66**(2): 10–32.
13. Davidson J, Lambert T, Goldacre M. Career pathways and destinations 18 years on among doctors who qualified in the UK in 1977: postal questionnaire survey. *BMJ* 1998; **317**(7170): 1425–1428.
14. Lloyd JR, Leese B. Career intentions and preferences of GP registrars in Yorkshire. *Br J Gen Pract* 2006; **56**: 280–282.
15. Lambert TW, Goldacre M, Turner G. Career choices of United Kingdom medical graduates of 2002: questionnaire survey. *Med Educ* 2006; **40**(6): 514–521.
16. Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: a meta-analytic review. *JAMA* 2002; **288**: 756–764.
17. Comstock LM, Hopper EM, Goodwin JM, Goodwin JS. Physician behaviours that correlate with patient satisfaction. *J Med Educ* 1982; **57**: 105–112.
18. Candib L, Lent B, Levitt C, for WWPWF. Women working through WONCA to be the best we can: women in practice. Monograph and Literature Review, section 3. http://www.womenandfamilymedicine.com/pages/draft_monograph.asp (accessed 12 Jan 2007).
19. Brooks F. Women in general practice: responding to the sexual division of labour? *Soc Sci Med* 1998; **47**(2): 181–193.
20. Schneider M, Phillips SP. A qualitative study of sexual harassment of female doctors by patients. *Soc Sci Med* 1997; **45**(5): 669–676.
21. Hooper J, Millar J, Schofield P, Ward G. Part-time women general practitioners — workload and remuneration. *J R Coll Gen Pract* 1989; **39**(327): 400–403.
22. Leese B, Young R, Sibbald B. GP principals leaving general practice in the UK — similarities and differences between men and women at different career stages. *Europ J Gen Pract* 2002; **8**(2): 62–68.
23. Sutherland VJ, Cooper CL. Identifying distress among general practitioners: predictors of psychological ill-health and job dissatisfaction. *Soc Sci Med* 1993; **37**(5): 575–581.
24. Hirshbein LD. Are women residency supervisors obligated to nurture? *Med Educ* 2006; **40**: 1159–1161.
25. Bower P, Campbell S, Bojke C, Sibbald B. Team structure, team climate and the quality of care in primary care: an observational study. *Qual Saf Health Care* 2003; **12**: 273–279.

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What's in a name?

Advances in primary care chronic pain management

Over the last 20 years or so, high quality epidemiological studies have repeatedly shown that chronic pain is common and important in primary care. Up to half of the population currently has pain that has been present for at least 3 months.¹ Studies using even the most exclusive case definitions have found that severe chronic pain is as common as ischaemic heart disease, diabetes or asthma (www.isdscotland.org). For example, high intensity, severely disabling chronic pain was found to affect

more than 5% of adults.² Chronic widespread pain is part of a clinically important spectrum at the far end of which is fibromyalgia, and can be defined specifically as 'pain that is present both in two contralateral quadrants of the body and in the axial skeleton, present for at least 3 months';³ the population prevalence of this is also at least 5%.^{4,5} These and other studies have consistently found that chronic pain is associated with poor physical, psychological and social health, and presents an enormous

burden to the individual, society and the health services. Over a quarter of people with chronic pain, and half of those with severe chronic pain, have sought treatment and professional advice recently and frequently,² most commonly in primary care.^{6,7}

The causes of chronic pain are diverse, but often remain unknown. However, many common risk factors have been identified for chronic pain of any cause, body site or diagnosis. Similarly, the impact and management needs appear to be largely