precisely what a well-organised maternity hospital should offer.

[1] Ministry of Health, Department of Health and Social Security, *Reports on Confidential Enquiries into Maternal Deaths in England and Wales 1952-1969*. London, HMSO, 1957-1972.
[2] Ministry of Health, *Report of the Maternity Services Committee*. London, HMSO, 1959.
[3] Butler, N R, and Bonham, D G, *Perinatal Mortality, First Report of British Perinatal Mortality Survey*. London, Livingstone, 1963.
[4] Butler, N R, and Alberman, E D, *Perinatal Problems, Second Report of British Perinatal Mortality Survey*. London, Livingstone, 1969.
[5] Department of Health and Social Security, Standing Maternity and Midwifery Advisory Committee, *Domiciliary Midwifery and Maternity Bed Needs*. London, HMSO, 1970.
[6] *Lancet*, 1974, 2, 1183.
[7] Russell, J K, *Lancet*, 1966, 1, 1315.
[8] Baird, D, *Obstetrical and Gynecological Survey*, 1965, **20**, 410.
[9] Baird, D, *Journal of Biosocial Science*, 1971, **3 suppl**, 93.
[10] De Hass-Porthuma, J H, *Proceedings of the Organisation for Health Research, Series A, no 11*, 220. The Hague, TNO, 1963.

Women in medicine

The new legislation[1] against sex discrimination in employment (which came into force last week) gives added topicality to the discussion of the problems of women in medicine published at p 78—the second session of the *BMJ* conference on medical manpower held at Canterbury in November. The proportion of women entering the medical profession has been rising in Western countries and has now reached nearly 40% in Britain and will reach 50% by the 1980s if current trends continue.[2] We are still, however, a long way from the female domination of medicine found in the USSR and some other communist states.

In the past far too many women doctors have dropped out of medicine within a few years of qualification in order to look after their husbands and children, and relatively few ever returned to full-time work. If this pattern of behaviour were to persist, its cost to society would rise with the rising numbers of women doctors and soon become unacceptably high. Recognition of this fact has led to some action by the Department of Health—its retainer and training schemes for women doctors—but the underlying problems have yet to be tackled with any real conviction.

Women do not seek, nor should they be given, any special treatment or favour on the grounds of sex when they compete with men at undergraduate or postgraduate levels on equal terms. While fewer than half the applicants for medical school places are women they may be expected to be (on average) academically better qualified than men, so it should not be surprising that their final examination results are better.[3] Any woman doctor who decides to make a career in a prestigious specialty such as neurology or cardiothoracic surgery will find that she is competing with men who give 100% of their effort to their work: she cannot expect to succeed if she tries to combine her specialist training with bringing up a family herself. It would be quite wrong for any modification to be made to the existing system to encourage part-time training in such demanding branches of medicine, for standards would inevitably fall.

But some men and more women will never want to pursue a career which demands near total commitment for many years. Some specialties are less demanding than others in terms of hours on call, the academic standard required in postgraduate examinations, and the competition for vacant posts. They also tend to be less popular—these are the shortage specialties, in which a disproportionately large number of hospital junior staff come from overseas and to which recruitment is difficult. Why expect women to fill these less attractive posts, it may be asked. The answer is that the selection factor is not sex: it is the wish for a less-than-maximum commitment.

There are many jobs in medicine that can be done part-time and yet provide worthwhile, satisfying careers. Married women need not be condemned—in Dr Tom Arie's phrase—to a soul-destroying routine of contraceptive clinics. Psychiatry, anaesthetics, and many other hospital disciplines; community health; and general practice can all provide work for part-timers if the good will and motivation are there. There are some financial anomalies which make for difficulties: for example, a general practitioner who wants to take on a part-time partner may find that the only way it can be done is to employ her as an assistant—at a considerable financial loss to the practice and the doctor concerned. In general, medical assistants are worse paid than doctors in the hospital practitioner grade—a consequence of the multiheaded negotiating system within the NHS, but an anomaly that causes serious resentment within the hospital service. Just as there is a clear case for the manpower policies for the whole NHS to come under the umbrella of a single planning unit, so too there should be closer comparability of all NHS salaries—and this should be possible since they are agreed within a single framework.

While openings exist in these specialties for part-time work—including part-time specialist training—there are still far too few career appointments which offer less than full-time contracts. In part this is simply inertia: if the establishment of a hospital has always been filled with whole-time and maximum part-time posts, it is simpler and easier to continue with the status quo. Furthermore, there are practical arguments against part-time appointments,[4] which inevitably will be advanced if suggestions for change are made.

But, as our conference showed, times are changing. Alterations in the taxation laws and improved hospital salary scales have made it more rewarding for young women doctors to continue working after marriage, and many more seem to be doing so—perhaps encouraged by the bleak economic climate. Those who dropped out a few years ago to have families are anxious to return to work—and, as Dr Peter Clark and others have shown, will do so eagerly given only a little active encouragement and practical help. Yet the arrangements are still amateurish and betray a Departmental attitude of laisser faire. Surely if nearly half our young doctors are women, most of whom will marry and have children, more formal provision should be made for part-time work in planing the staffing structure of the NHS. One of the Service's unsolved problems is the disparity between the numbers of training posts needed in the hospital service and the numbers needed to staff the junior grades. Part of the solution could come from more and better use of the pool of medical women willing to work part time. The recent legislation about equal opportunity gives an impression of politically motivated window-dressing rather than real reform. What is wanted in the NHS is practical provision for the needs of women who wish to combine medicine with marriage without damage to the standards of either.

[1] Sex Discrimination Act, 1975.
[2] Bewley, B, *Lancet*, 1975, 2, 270.
[3] Stanley, G R, and Last, J M, *British Journal of Medical Education*, 1968, 2, 204.
[4] Dollery, C T, *British Medical Journal*, 1975, 4, 750.