Can we write a new holy book that is useful, and chuck out the defunct Victorian and Galenic terms?

Des Spence on heresy, p 47

PERSONAL VIEW **Jane Dacre**

We need female doctors at all levels and in all specialties

Several reports in recent years have pointed out the increasing numbers of female doctors.[1] This trend should now stop being a news item. The profession should adapt to its contemporary demographic, take pride in its gender balance, and make plans for more women at the top.

The NHS continues to struggle to provide the best quality service for its patients in a difficult financial climate. To support this quest, we need to make the best use of the entire medical workforce. The NHS Future Forum has acknowledged the under-representation of women in senior leadership positions and the need for appropriate development opportunities,[2] without which we risk reducing the talent pool.

In medicine, we have been successful at supporting women to achieve consultant status. In 2009 the Royal College of Physicians published its report *Women and Medicine: The Future*. This comprehensive piece of research accurately collated the available data about the numbers of women in medicine. The findings supported the prediction that women will be in the majority in the medical workforce from 2017, and in general practice in 2013.[3] These data, predicting a small majority of women, have been highlighted in the medical and lay press.

Several articles have reflected on the future of a medical profession with an increased number of women. These articles express concerns, including: a reduction in the political power of a profession led by women[4]; increased costs because of a fall in the number of consultations completed per hour[5]; difficulties with cover if women are working part time[6]; and gender segregation, with some specialties—such as psychiatry—becoming female dominated, with a potential reduction in the number of applicants to specialties that have been traditionally male dominated.[7 8]

As a profession, isn't it time we moved on? Medicine has been led by men for more than 500 years, since the inauguration of the medical royal colleges. We have recently been successful at recruiting high quality women into this traditionally male domain, which is an achievement to be proud of and something that surely will soon stop being newsworthy.

ROB WHITE

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As a society we are committed to the principles of equality and diversity, and we aspire to achieve high standards in the way we treat people who are different from ourselves. This aspiration is enshrined in the law and results in a diverse population, a diverse pool of patients, and a constantly changing UK demographic. Changes in the medical profession's demographic reflect the developing contribution of a different mix of people, but people who have earned their place and are capable of excellence.

The predicted increase in the number of female doctors will happen, with the gender ratio in medical schools having settled at about 60:40 in favour of women. These men and women have a responsibility to provide the best possible care to our patients, whatever their numbers. We should stop worrying about the balance and continue to make plans for a change that is inevitable and welcome. Such plans will include identifying solutions to the concerns mentioned above and encouraging potential female medical leaders. The increased availability of part time working and flexibility of working patterns will be a good start, as is the encouragement of women into areas of medicine where they are traditionally under-represented. Increasing flexibility in the way we deliver care will allow more creative working patterns that are family friendly. It will provide opportunities to develop rotas that balance work with domestic responsibilities.

As the delivery of healthcare changes and more patients are managed outside the hospital setting, more doctors will be needed to train in primary care, psychiatry, and the outpatient specialties. These specialties are currently favoured by women, and are more easily adaptable to part time working. The NHS needs more general practitioners and psychiatrists, so the increase in women may help to solve some of the current recruitment problems.

Both male and female doctors have a responsibility to ensure that we become a profession of true gender equality. This means taking professional responsibilities seriously. Women should ensure that they endeavour to organise their domestic commitments around their work. More senior women also need to be prepared to take on leadership positions and to become role models for those coming through the training grades. The numbers of women in medicine reaching the age at which leadership opportunities present themselves (around the age of 50) is increasing. I hope these women will put themselves forward when the opportunities arise. Indeed, many argue that the collaborative leadership style favoured by women[9] works well in complex systems such as the NHS and higher education.

The skills necessary to become a doctor are not gender specific, and the workplace is richer for its diversity.

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Competing interests: JD was the chairwoman of the Royal College of Physicians research steering group on women and medicine.

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References are in the version on bmj.com.

FROM THE FRONTLINE **Des Spence**

Medical heresy: ditch the eponyms

There are hundreds of eponymous medical syndromes and signs, often with fantastic double barrelled names with exotic connections to central Europe. I like to imagine that the eponyms were made up by Victorian doctors who lived in smoggy and grim towns like Sheffield, Sunderland, and Middlesbrough to give the signs more gravitas.

Today, MacLeod's *Clinical Examination* is still the bible of clinical examination and heaves with these signs. The medical gunners still squeal in delight as they recite these signs on consultant ward rounds. Medical students still promise to buy their flatmates a drink if they allow them to practise clinical examinations on them. The way we teach examination has changed little. Medicine is a faith based profession, and examination is the religious ritual; the stethoscope is our incense and medical words our incantation. But examination techniques were born long before definitive investigations.

Medicine is a faith based profession, and examination is the religious ritual; the stethoscope is our incense and medical words our incantation

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And as with most organised faiths, pointing out obvious flaws in the system leads to anger, defensiveness, and accusations of unprofessionalism. And there is always the threat of excommunication. Our most senior medical clerics sermonise the infallibility of clinical examination. They demand blind acceptance even when traditional teaching is completely devoid of an evidence base on the specificity, sensitivity, and predictive values of these examinations. The evidence, such that it is, often comes from skewed hospital populations. A small, disparate band of medical secularists quietly get on with their humanist practices, shunning the diktats and doctrines of the established medical church.

This heretic openly calls for the medical profession to disestablish itself from the traditionalist examination dogma. We need to look afresh at our holy scriptures. Can we attempt to rationalise what we do? Can we write a new holy book that is useful, and chuck out the defunct Victorian and Galenic terms? For example, we teach Rovsing's sign for appendicitis, a sign I have never found useful, yet it was an old general practitioner who taught me the hop test. If a patient can hop freely it excludes local abdominal peritonism, such as appendicitis, pelvic inflammatory disease, and even meningism.

Also, a technological revolution is coming with prototypes that convert an iPad into a portable ultrasound machine (http://bit.ly/H9O7hl). We should teach ultrasonography. With all the time spent teaching examination technique, I am sure that medical students could become proficient in ultrasonography. We need a renaissance in medicine because believing in accepted medical convention is like believing in the Easter bunny—and often a lot less plausible.

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IN AND OUT OF HOSPITAL **James Owen Drife**

The late show

Comedians are living longer these days. In the past century few reached their 70s, and one or two famously died on stage aged around 60. Comedy, like medicine, benefits from the authority that comes with age, but it is a hard life and these days its practitioners tend to ease up as they get older. Even Dame Edna Everage, now 78, is hanging up her frock.

All the more remarkable, then, is that Britain's most successful comic, Ken Dodd, is still touring at the age of 84. He recently filled a 1500 seat theatre in Leeds, and tickets were scarce. Venues used to print their brochures with "Sold Out" over his picture, and a woman behind me said that she had been trying for years to see him perform.

We knew what we were in for. He came on at 7 pm and was scheduled to finish at midnight. Neither of his supporting acts was very long. During the interval, at 9.30 pm, the audience swapped reminiscences ("Last time he went on till . . .") and then filed back with a determined air. We would see this through.

He was wonderful. His troublesome cough soon disappeared. There were fresh stories, silly images, sharp observations, songs, and cheerful self deprecation. The show, with its costume changes and two man band, was carefully structured. What a joy to hear five hours of jokes with no swearing. (His comment on modern stand ups: "I blame the parents. They learn that language at home, you know.")

He still does his ventriloquist act. Near the end he and Dicky Mint shared a quiet conversation under a single spotlight. People stood up to take photos, suddenly aware that this was living history.

Comedy, like medicine, benefits from the authority that comes with age, but it is a hard life and these days its practitioners tend to ease up as they get older

Indeed it was. In the 1950s he had played the Leeds Empire ("None of you remember it." . . . "Oh yes we do!") where a woman at the top of the bill advised him, "Always leave them with a tearful earful." Tonight it came naturally. Another famous contemporary had died, and Doddy, pointing out that we really were watching the last of the red nosed comics, sang "Absent Friends."

As we emerged, a coach was waiting to take an elderly group home, 60 miles away; tired but happy, no doubt. A man with no agenda except generating laughter is worth a long bus trip, even after midnight. And it's nice to see a professional your own age; a pleasure that you can't get on the National Health.

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BETWEEN THE LINES **Theodore Dalrymple**

The *Round Britain Quiz*

When I was young and aspiring to be an intellectual I used to listen to the *Round Britain Quiz* on BBC Radio 4, whose formidable contestants were sent cryptic questions by listeners that required for an answer both encyclopaedic knowledge and the skills of a cryptographer. How do you connect an Italian prime minister, a palace in Venice, and the heart of the matter? The answer (I will refrain from adding "of course") is the nitty gritty: Nitti having been a prime minister of Italy, the Gritti being a palace in Venice, and the nitty gritty being . . . well, need I go on?

Here's a question, then, for the quiz: how do you connect arrested hydrocephalus, the two volumes of *English Sanitary Institutions*, and the lines: "I will go back to the great sweet mother, / Mother and lover of men, the sea. / I will go down to her, I and none other, / Close with her, kiss her and mix her with me . . ."

The answer—there is no time or space for questions and clues à la the *Round Britain Quiz*—is Algernon Charles Swinburne (1837-1909). According to the pathologist William B Ober, who wrote many essays on the pathography of authors, Swinburne experienced anoxic brain damage at birth as a result of his large head (a state of arrested hydrocephalus). This anoxic damage manifested itself in Swinburne's lifelong choreiform movements, his dysgraphia, tics, and hyperkinesis, as well as in his masochism. Portraits of Swinburne indeed show him as having a massive upper head by comparison with the rest of his body.

The lines quoted above are from "The Triumph of Time," the long lament that he wrote after his one and only disappointment in love, after which he swore that he would never marry. And he never did. According to Harold Nicolson's book *Swinburne* (1926), and other sources, the loved one was Jane Faulkner, the foster daughter of Sir John Simon—

How do you connect arrested hydrocephalus, *English Sanitary Institutions*, and the lines: "I will go back to the great sweet mother, / Mother and lover of men, the sea"?

Swinburne: big headed

surgeon, public health pioneer, and later author of *English Sanitary Institutions*. Jane was fostered because her mother, Sir John's sister, had died when she was young.

Sir John, whose sanitary reports were quoted by Karl Marx, kept a literary salon that luminaries such as John Ruskin attended, as did Swinburne. The latter addressed verses to Jane, who was scarcely more than 10 years old at the time. According to legend, he offered to marry her but she laughed at him; there was an altercation between them and he fled the house never to return. He then wrote his poem that quivers with misery: "I shall go my ways, tread out my measure, / Fill the days of my daily breath / With fugitive things not good to treasure . . ."

Not everyone accepts that Jane Faulkner was the object of Swinburne's one and only love; another candidate was his cousin, Mary Gordon. But, by strange coincidence, both Swinburne and Jane Faulkner became what were then known as dipsomaniacs. Swinburne, who had several times experienced delirium tremens, was rescued from alcoholism by his friendship with Theodore Watts-Dunton, a solicitor, literary critic, and celebrity hunter, who took him to live at the unpoetical address of 2, The Pines, Putney, where, for 30 years, Watts-Dunton allowed Swinburne only one beer at lunchtime. It is, however, generally agreed that the quality of Swinburne's poetry, unlike his body, never recovered.

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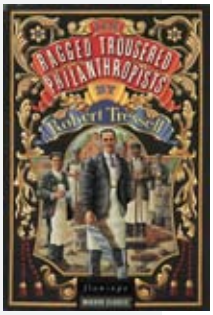
MEDICAL CLASSICS

The Ragged-Trousered Philanthropists

By Robert Tressell; first published 1914

Sixpence ha'penny an hour; one pound, one shilling, and eight pence a week: these starvation wages buy the lives of Robert Tressell's working men, painters, and decorators, who live in poverty and constant fear of being "stood off" from the job. They eat bread and margarine, inherit cast off shoes, pawn their possessions, or take cheaper lodgings to save themselves from destitution. And they die young, from accidents in the workplace or exhaustion in the workhouse.

"There's always been rich and poor in the world and there always will be," they opine. All agree that, "the likes of us can't expect to 'ave nothing better, and as for our children wot's been good enough for us is good enough for the likes of them."



The novel's protagonist Frank Owen is angered by the condition of his fellow workers. He endeavours to explain the causes of their poverty, to convince them "that the system that produced such results was rotted and should be altered," and to persuade them that socialism offers a viable alternative.

But the men are uninterested in Owen's efforts. "Bloody rot, I call it . . . Wot the 'ell's the use of the likes of us troublin' our 'eads about politics?" asks one. "Argyfying about politics generally ends up with a bloody row an' does no good to nobody," concludes another. These workers are the "ragged trousered philanthropists" of the book's title: willing, apparently, to donate the products of their labour to their masters.

Ironic, unsentimental, yet empathetic, the book's depictions of deprivation, the anecdotes, the working men's vernacular, and their political inertia draw upon Tressell's experiences as a working class tradesman at the end of the 19th century. Tressell's opinions are often voiced in the novel by Owen, whose observation appears to prefigure the establishment of Britain's welfare state: "a very great number—in fact, the majority of people—lived on the verge of want; and that a smaller but still very large number lived lives of semi-starvation from the cradle to the grave."

With no national health system, each week the men put a few pennies in a hospital collection box and some joined a so called sick benefit club, similar to insurance. However, "Owen's ill-health rendered him ineligible for membership of such societies" and medical readers will recognise tuberculosis in Owen's haemoptysis, breathlessness, and exhaustion: the final tragic self fictionalisation of the author, who died from tuberculosis in 1911 aged 40, leaving a young daughter and his massive unpublished manuscript.

Health and social care have improved considerably since the novel was written, but gross inequities and the consequent health and social consequences persist. In the recent riots Tressell would no doubt have recognised the failings of capitalism and a society still segregated by class. In the speed of politicians to deny that these events were political he would have seen only their avoidance of responsibility.

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