TALKING POINT

A woman's place is in the wrong

EVA LESTER

Minorities suffer from generalisations and extrapolations based on the behaviour of their most conspicuous members. When one of a majority group behaves in an unusual way he is considered deviant and his behaviour unrepresentative of the rest of the group. Women in medicine are the victims of generalisations derived not only from the behaviour of the occasional woman who is more idle and irresponsible than the rest, but also from the behaviour of the occasional woman who is more brilliant and dedicated than the rest. The apocryphal story told about every female professor of medicine, consultant surgeon, or president of a professional body who ever produced a child, that she went into labour during her weekly ward round, operating list, or committee meeting, calmly finished it, was admitted to the labour ward, and was back at the ward round, list, or committee meeting the next week, is used against the more usual woman who wants to take the maternity leave to which she is entitled. Ironically, women also suffer from generalisations about the male majority of the medical profession who are represented as being invariably totally dedicated to their work and the good of their patients. Whoever heard of a male consultant leaving his ward round to his registrar to visit a test match or who having all his sessions at two hospitals could frequently not be located at either?

There are as many sorts of women as there are women but, as an advance on the present policy of lumping them all together and dealing with them as second-class men in relation to their professional problems, they can be divided into three groups. At one extreme is the small number who, having married and produced a family, are happy to retire from professional work and devote themselves to being wives and mothers. At the other extreme are the women whose approach to their careers is indistinguishable from that of men. They may also marry and have children but, apart from the process of giving birth, they require no concession to their sex. Their children are entrusted to a nanny (or succession of nannies) in the same way as men's children are entrusted to a wife (usually more permanent). Minor family crises affect them only peripherally. Unfortunately, most women fall into an intermediate untidy group wanting to combine the jobs of doctor and mother. For them the need is not to devise unsatisfactory ways in which games can be played according to the rules laid down for men but to define different rules for women.

When women ask for part-time work so that they can be at home when their children return from school it is regarded as an unreasonable demand, a special concession. It is as though, if they were able to leave work early, they would spend the extra couple of hours playing bingo or taking flower-arranging classes. Life is complex for women doctors who have children as well as professional work. There is no army of reliable part-time nannies or domestic staff to act as substitutes for them at home and there are no crèches. For older children few families, even with two salaries, can afford boarding school fees. Even if these solutions were available, attitudes in the last 50 years have moved away from total delegation of child care. Even Dr Spock, for whom in the 1960s almost anything went, had reservations about full-time working mothers. As he evasively put it in a chapter headed "Special problems" in his book on child care,

"A few mothers, particularly those with professional training, feel that they must work because they wouldn't be happy otherwise. I wouldn't disagree if a mother felt strongly about it, provided she had an ideal arrangement for her children's care."¹

The inviolability of the present organisation of hospital medical work is based on a mystical belief that everything must be as it has always appeared to be, but appearances were deceptive in the past and changes have constantly taken place. The fragmentation of medical care which has become acceptable through force of circumstances over the last 15 years would have been unthinkable before junior doctors found their voice. In the early 1960s the need for continuity of medical care was the lever used to confine resident medical staff for 24 hours a day of the entire six months of more than one house job in my own teaching hospital. The advantages to the patient of seeing a doctor who knew him were considerably diminished by the state of mind induced in the doctor by exhaustion and incarceration. On the other hand, the present system, where it is not unknown for patients to be left at clocking-off time to the care of another team with only the most perfunctory transmission of information about them, was not introduced with the welfare of patients in mind. The fragmentation of medical care by senior medical staff has been so widely accepted for so long that it is only considered in order to be denied, quite unjustifiably, when part-time jobs for married women are being discussed.

No magic in total commitment

Though rationalisation of hospital services should reduce the number of jobs where consultant sessions are divided among several hospitals, the increasing separation of private medical facilities from NHS hospitals is already having the reverse effect. Unfortunately, those legislators whose political philosophy leads them to oppose private medicine and to try to establish full-time consultant posts in one place for everyone are not interested in the needs of married women for part-time work.

There may be jobs in medicine which can only be done by doctors willing to hold themselves available at all times. But once the possibility is accepted that there are many jobs which require less than total denial of any other commitments there is no inherent magic in the concept of 11, 10, or even nine sessions. On-call work is often less of a problem for married women doctors than the routine daytime hours because their husbands are usually more reliable childminders than au pairs. The whole structure of afternoon outpatients' clinics would not be destroyed if they ran from 1 pm to 4 pm instead of from 2 pm until 5 pm. Some clinics run beyond their allotted time but this is usually only because the doctor started late. Since service departments are increasingly incapable of persuading their technical staff to stay until the job is completed, patients seen later in the day often have to return for investigations and an earlier start would be to their advantage.

Decisions about which jobs lend themselves to less than the present full-time definition should be based on rational thought rather than on dogma. The main need is for flexibility and for the administrative will to implement the flexible arrangements once they have been made. As long ago as 1969 the DHSS recognised the need for part-time training posts for women doctors with small children. But only a few doctors have been able to take advantage of the provisions of HM(69)6² and the

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only survivors are the minority whose heads are harder than the brick wall of administrative inertia. The need for part-time consultant posts for women doctors with small children has still not been recognised, though women are often advised to obtain higher qualifications before starting a family.

Almost half the entrants to medical schools are now women so that unless some solution is found which recognises that sexual differences exist the economic consequences of playing at ostriches will be considerable. An obvious alternative solution would be to reduce the intake of women students and increase the intake of men. Despite horror stories about the "A" level entrance requirements of medical schools, most students are still sufficiently lacking in intellectual brilliance to reassure their teachers, if not their patients, that no new race of supermedicos is being produced. If the number of men entering medicine is doubled the increase in quantity of manpower may not compensate for the loss in quality. Furthermore, Parliament, which by its introduction of the Sex Discrimination Act in 1975 apparently recognised that legislation might be appropriate to deal with

prejudice, is unlikely to regard this as an acceptable solution, especially since half the country's voters are women. The ludicrous aspects of the implementation of the Act have stemmed from interpretations which, I hope, were never intended, that women can and should do everything that men can and often should not do. The right to be served at the bar at El Vino's is apparently vital to some women. For many of those in medicine some action from the DHSS, translated into reality by the tiers of administration so that they could avoid taking the present unnecessary all-or-nothing choices, would be a more useful application.

References

- 1 Spock, B, *Baby and Child Care*. New York, Pocket Books Inc, 1961.
- 2 DHSS, *Re-employment of Women Doctors*, HM(69)6. London, DHSS, 1969.

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Phased award for service doctors

The Government published preliminary details of the 1978 award to armed Forces doctors on 22 August (2 September, p 711) in advance of publication of the report, which was held up by a dispute at the Stationery Office. The full report—a supplement to the Seventh Report of the Review Body on Armed Forces Pay—was finally published on 11 December.

The Review Body on Armed Forces Pay, chaired by Sir Harold Atcherley, has been making "a comprehensive examination of the basis of doctors' and dentists' pay in the armed Forces." Its report states, however, that "we are not yet in a position to draw conclusions from it." According to the report, "the current levels of the medical and dental military salary are substantially lower than those that are justified on the basis of outside evidence, as established in the Eighth Report of the Review Body on Doctors' and Dentists' Remuneration, and a substantial shortfall exists. . . . An increase within the guidelines for Service doctors and dentists will still leave a shortfall." The Review Body recommends a phased pay award averaging 30%, with the full recommended increases to be given not later than 1 April 1980. The late publication of this report has meant that events have overtaken its recommendations, the first phase of which were based on an average net remuneration for NHS GPs of £9785. The Government, however, approved a more substantial movement than proposed by the Armed Forces Review Body towards the fully appropriate rates, in line with the overall award made to the rest of the armed Forces. This award averaged 14% (as compared with 10.6% proposed by the Review Body for Service doctors) and the military salaries based on this average were those announced on 22 August (see table).

In their evidence both the BMA and the Ministry of Defence refer to serious shortages of doctors in the Army and Navy and to some deterioration in the Royal Air Force (table II). Furthermore, recruitment for 1976-8 is not sufficient to replace those doctors who have left. The numbers of preregistration medical practitioners and cadets have fallen and since 1974 there has also been a marked decrease in the number of doctors converting from short service to regular commissions. The BMA forecast that premature retirements would increase in the next few years, and the Ministry of Defence agreed that recruitment was inhibited by "non-competitive" rewards for medical cadets as a result of the junior doctors' new contract.

X factor

Despite evidence from the BMA and the Ministry requesting that the X factor (additional pay in recognition of the exigencies of Service life) for doctors be increased—the BMA wants the same level as for other combatant Service personnel (10% for men and 5% for women) on the grounds that as well as "medical unsocial hours" (recognised in NHS GPs' average net remuneration) Service doctors were also entitled to the "unsocial" payments for military duties—the Review Body has recommended that it should remain at 6½%. The Review Body also declined to accept the BMA's interpretation of the 1969 National Board for Prices and Incomes' report about parity with GPs' earnings. The Review Body has always used the average net earnings (after practice expenses) from the NHS alone as the yardstick; the BMA wants Service

New consultant contract

Draft circular

At its last meeting the CCHMS approved a draft implementation circular and job description for the new consultant contract (16 December, p 1730). To give employing authorities the opportunity to make plans for implementing the new contract, the circular is being sent to them on an *information only* basis. At the same time arrangements are being made for each consultant to receive a copy.

The CCHMS has emphasised that the issue of the circular *in no way pre-empts the profession's decision about accepting the new contract*. This decision will not be taken until the pricing is known.

doctors aligned with NHS GPs' total earnings. But the report acknowledges that changes have occurred since 1969 in the way that NHS GPs have been paid and these will be taken into account in the comprehensive review.

The structure and level of medical additional pay—diploma, specialist, senior specialist, and consultant—are also under review by the Ministry of Defence, which will be giving evidence to the Review Body next year on these items.

The BMA's Armed Forces Committee had a preliminary look at the report on 13 December. It condemned the report as negative and regretted that nothing had been done "beyond an award . . . which shows they had not realised the urgency of the problem." Valid points that the Association had made had been disregarded. In a statement the committee said that in oral evidence to the Review Body the BMA had made the equation of the present analogue to the total earnings of NHS general practitioners a "matter of confidence in the Review Body." It declared that the Review Body had lamentably failed to reflect this.

Military salaries inclusive of X factor for Service medical and dental officers from captain to colonel (annual rates)*

Rank	Pay to 1 April 1978 £	Fully recommended rates of pay £	Pay from 1 April 1978 £
Brigadier	11 209	14 500	12 650
Colonel	10 275 to 10 614	13 753 to 14 217	11 811 to 12 213
Lt-Colonel	9 114 to 10 154	12 220 to 13 644	10 486 to 11 713
Major	9 259 to 8 776	10 618 to 11 753	9 183 to 10 059
Captain	6 518 to 7 237	8 223 to 9 213	7 154 to 8 004
Preregistration medical practitioners	4328	6400	5398
Cadets	2635	3000	3000

*Rounded to the nearest £