Women in medicine
Margaret E Sprackling, MRCP; Angela V Taylor, MB; Judith M Millar, MRCP... 339

High-pressure medicine
I C F Wisely, MB, DA... 340

Dispersal of biliary calculi by irrigation
J A Powis, FRCS... 340

Academic general practice
Mary Knowles, FFARCS; B Caplan, MRCP... 341

Renal masses and ultrasound
R J Burwood, FRCS... 341

Prevalence of gall stones in Dundee, 1974-5
M C Bateson, MRCP... 341

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CORRESPONDENCE

Women in medicine

Sir,—I should like through your columns to comment on several of the points raised in your leading article (10 January, p 56).

First I should like to raise the question of "total commitment" of the individual doctor. Surely you are not inferring that doctors in less "prestigious" specialties (whatever that means) give less than 100% of their effort to work, bearing in mind, of course, that most doctors in other specialties will also be men. This would be a most invidious suggestion and one to be strongly resisted. Allied to this is the concept that some jobs are less "demanding" than others and that these tend to be the less popular ones. Again, I should like to see the evidence for this, especially as common sense suggests the opposite. For instance, why is it thought to be less "demanding" to have 150 beds than to have as few as 10 (or even eight)? Why is it thought to be less "demanding" to take the responsibility for the work of low-calibre junior staff (not my personal problem, I hasten to add) or to do their work if junior posts remain unfilled than to have a well-staffed department containing the cream of the medical schools' output? Why is it thought less "demanding" to work in isolation, both professional and topographical; or to work in a region grossly under-capitalised since the inception of the Health Service, where there is a continuous struggle to get the most basic amenities for patient care? Surely it must be more "demanding," and this is precisely the reason why such specialties as radiology, anaesthetics, psychiatry, geriatrics, and venereology are less popular. Medical staff in these "Cinderella" specialties will, I am sure, refute any suggestion that they have a "less than maximum commitment." Rather are they totally committed, as indeed they must be, to tackle such heavy clinical work loads in such difficult circumstances. The staffing problems of these long-neglected specialties will be solved only when conditions in them are made more attractive, and this necessitates changes in attitude. Failure to understand the per-putuating factors not only is counterproductive but helps to maintain the vicious spiral of unpopularity/deprivation. Of course these specialties would benefit from the influx of good women graduates, as they would from good men graduates. However, the suggestion that women should fill these unpopular posts is not really the answer, based as it seems to be on the principle that by putting two unrelated problems together the solution to one or both might be achieved.

Although not all women doctors marry or have children, the discussion about career patterns was focused on those with children. Just to put matters in perspective, perhaps I should point out that nowadays many men, including doctors, take an active part in bringing up their own children and occasionally this may be a major part. Also men doctors, as well as women doctors, have other family responsibilities, including aging parents, siblings, or a spouse with chronic physical or psychiatric disability. Compared to these dependants, whose dependency may go on for years and possibly increase, the infant stage of childhood is over relatively quickly. However, I have never heard the suggestion that men doctors with such family responsibilities should be debarred from certain specialties or part-time specialist training or drafted into unpopular specialties because of them. Yet using your logic this should follow.

Part-time specialist training is another point I should like to take up. Both the Murren Committee1 and the Joint Committee for Higher Medical Training2 endorse the desirability of part-time training and neither limits this to, or excludes, any specialty. The JCHCT recommends half-time or more, and this I would agree seems reasonable, as with fewer sessions the training period would become attenuated to an unacceptable degree. Part-time specialist training might be needed by a proportion of married women with young children, but others will have their family first before starting full-time specialist training and others will defer starting a family until training is completed. If you have any evidence that part-time training in any specialty has led, or would lead, to a fall in standards I should be interested to see it.

As an expression of your opinion, I have no objection to any of your comments, although I might not agree with them. As recommendations which will affect the professional careers, and therefore the lives, of others, I feel that evidence should be produced and scrutinised before such recommendations are carried out. It has always been my contention that conditions which are bad for women are bad for some men. For the reasons given above and for reasons of personal physical or psychiatric ill health there will always be men doctors, too, who will want part-time work and part-time specialist training. A fundamentally more flexible approach will help individual doctors and the NHS in general.

M E Sprackling
President, East Midlands Association, Medical Women's Federation

Geriatric Unit, Sherwood Hospital, Nottingham