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Women and medicine: exploited as staff and as patients

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Doctors and politicians have something in common. You might view their work as a performance. The best actors know how to stand, how to listen, and how to talk (doi:10.1136/bmj.q364).[1] One difference, however, is that doctors have sworn a vow to act in the best interests of their patients. Modern politicians seem to have sworn a vow to act only in their own best interests. This clash of priorities is evident in the global collapse in public services. Why wouldn't there, for example, be a concerted effort to resolve the childcare failures that are causing untold stress and deepening the health workforce crisis?

The burden of childcare falls unequally on women, and previous reports have highlighted how parenthood disproportionately affects the careers of female doctors. In short, women are being differentially exploited in their attempts to balance work and life commitments. The cause of equity is further set back by the way companies hijack feminist agendas to sell products (doi:10.1136/bmj-2023-076710 doi:10.1136/bmj.q314),[2,3] positioning non-evidence based interventions as a right.

Both the stresses and complications of childcare and contending with overdiagnosis and overtreatment add to staff discontent. A motivated, satisfied workforce delivers better patient outcomes—which is in the best interests of people's wellbeing and a country's economy. Criticising staff for a lack of productivity and resilience in these circumstances, apart from being insulting, isn't going to work. Naturally, the complications of childcare affect productivity, but the situation is an almost impossible one for many working parents.

A more helpful approach is to understand the root causes of discontent. Pay is one of those, but so are student debt, training opportunities, workplace culture, and career progression (doi:10.1136/bmj.p2888).[4] We surveyed readers to understand the toll of childcare, which is a particular problem for doctors in training. Our survey wasn't high science, but the signal from readers is clear: securing childcare to cover erratic and long working hours is draining, stressful, and a financial burden (doi:10.1136/bmj.q128).[5]

Organising childcare (doi:10.1136/bmj.q285),[6] balancing careers (doi:10.1136/bmj.q319),[7] and unaffordable costs make being a doctor unsustainable for many parents and persuade others to leave the profession in the middle of a retention crisis. Three quarters of respondents said that the problems with childcare dictated how many children they had and when they had them.

In these hard circumstances women may gravitate towards a career in primary care, which should be a career of choice rather than a destination of last resort. A new report by the UK health think tank the King's Fund finds that funding for primary care has decreased despite a rise in the number of GP appointments (doi:10.1136/bmj.q389).[8] An imbalance in funding growth has favoured acute care hospital services, themselves stretched by demand and industrial action (doi:10.1136/bmj.q361).[9] NHS consultant numbers grew by 18% over the five years to 2022, with an equivalent 4% rise in numbers of GPs. Staff vacancies in social care rose by 40 000 over a two year period. This is a dismal picture of an embattled workforce propping up a collapsing service (doi:10.1136/bmj.q368).[10]

A better integrated and appropriately resourced service would be more adept at implementing new evidence on the value of exercise to people with depression (doi:10.1136/bmj-2023-07584 doi:10.1136/bmj.q320)[11,12]; managing the complex drivers and clinical effects of frailty (doi:10.1136/bmj.q348 doi:10.1136/bmj.q116)[13,14]; supporting cognitive dysfunction after covid-19 (doi:10.1136/bmj-2023-075387)[15]; responding to the underlying causes of a rise in measles cases (doi:10.1136/bmj.q359)[16]; and optimising our response to the risks of diabetes and liver disease (doi:10.1136/bmj-2023-076388 doi:10.1136/bmj.q309),[17,18] the high burden of anticholinergic medication (doi:10.1136/bmj-2023-075708),[19] and the safe prescription of thiazide diuretics (doi:10.1136/bmj-2023-075174).[20]

The idea of one service across public health, community care, and hospital care is easily described but devilishly difficult to implement. But this doesn't mean that it's an idea to be rejected or ignored. It isn't an excuse to destroy the foundations of each building block. The latest example is the government's decision to defund its recently created Office for Health Improvement and Disparities—another blow in the systematic destruction of public health and the zealous disregard for the centrality of inequalities to population health (doi:10.1136/bmj.q389).[21] In all of this, the deep "disparities" in career opportunities must be tackled, along with the commercial influences that perpetuate the exploitation of women as staff, carers, and patients.

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