

Education and debate

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Women doctors and their careers: what now?

Isobel Allen

Outmoded career structures and attitudes mean that the UK risks losing out on the valuable contribution women doctors can make, especially in the second half of their careers

Many people in the medical profession still view women doctors with scepticism despite their increasing numbers. It is nearly 20 years since I was commissioned by the Department of Health to help them assess the implications of the fact that women would soon account for half of medical graduates.¹ That research and its follow-up² found that both men and women experienced similar problems and constraints in their careers, suffering from what they regarded as a rigid and conservative career structure. They overwhelmingly supported the provision of more flexible working patterns so that all doctors could lead a normal life. How far have women doctors progressed and what do they feel about the profession?

Change in culture

In 1986, many trainees had to work 120 hours a week and move to different locations every few months. Women were asked the most outrageous questions at interviews, the old boy network and behind the scenes telephone calls were dominant factors in the selection process, and women who wanted to reduce their hours to spend time with their children were not regarded as proper doctors. Things have changed in medicine, but perhaps not as fast as in the outside world. Powerful and influential doctors continue to express fears that the increasing proportion of women in medicine will lead to a loss of power and influence and professional status.^{3,4} But even if their fears were well founded, the progress of women in medicine is less than many people imagine.

Entry to medical school

Women are indeed accounting for a larger proportion of medical graduates. All through the 1960s women accounted for about 25% of those entering medical school. By 1975 the proportion was 35%, rising to 46% by 1985. In the early 1990s the proportion was around 50% but has since increased each year and is now 61%.⁵

But just because the proportion of women has increased over the past few years, it does not necessarily mean that it will go on increasing. We should be careful before saying that on present trends women doctors will outnumber men doctors by 2012.⁶ In neither hospital medicine nor general practice have women reached even 40% of the medical workforce.

Hospital medicine

Women accounted for 23% of all grades in hospital medicine in 1983, rising to 35% in 2003, hardly swamping the medical workforce (fig 1).^{7,8} The proportion of women consultants doubled from 12% in 1983 to 24% in 2003 and reached 25% in 2004. Women account for 39% of specialist registrars (the consultants of tomorrow) and for 44% of senior house officers. It is only among preregistration house officers that women are now in the majority, but still only just over 50%.

One of the reasons for the relatively low representation of women in postgraduate training grades is that as many as 42% of senior house officers and 38% of specialist registrars qualified outside the UK, and most of these are men.⁸ Traditionally, most overseas qualified trainees return to their home countries when they complete their training and do not take consultant posts. If we look at UK qualifiers, women account for 50% of senior house officers and 44% of specialist registrars.

The specialties with the largest proportions of women consultants in 1983 were psychiatry, pathology, and paediatrics (fig 2). Today paediatrics is now well in the lead with 40% women consultants. It is interesting that paediatrics with its on-call and out of hours commitment—things that women are supposed to

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Women doctors still account for less than half of the UK medical workforce



Further data are on bmj.com

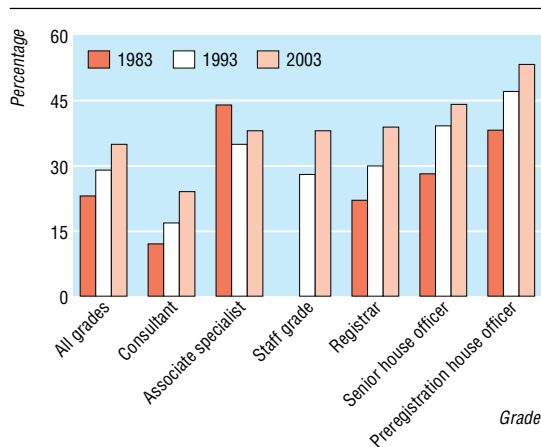


Fig 1 Percentage of female hospital doctors by grade

shun—is the leading specialty. The number of women consultants has also increased greatly in acute specialties like obstetrics and gynaecology and accident and emergency. Surgery, however, remains a male preserve, with only 7% of consultants being female in 2003.^{7, 8} Around 30% of women consultants now work less than full time.⁸ Women account for a higher proportion of specialist registrars, but the overall pattern is similar to that for consultants (see bmj.com).

Women in general practice

The proportion of women working in general practice has doubled from 19% in 1983 to 38% (see bmj.com). The proportion of women principals has more than doubled from 17% to 35%, but the biggest increase is among general practice registrars: from 37% to 60%.^{9, 10}

Between 1993 and 2003 the proportion of male principals working full time remained over 90% but the proportion of women fell sharply from 73% to 53%.^{9, 10} If only just over half of women principals are working full time, it is unsurprising that we urgently need to increase numbers entering general practice. These figures reflect the age profile of women in general practice, with high proportions of younger women with child care responsibilities. These women may increase their hours when their children are older.

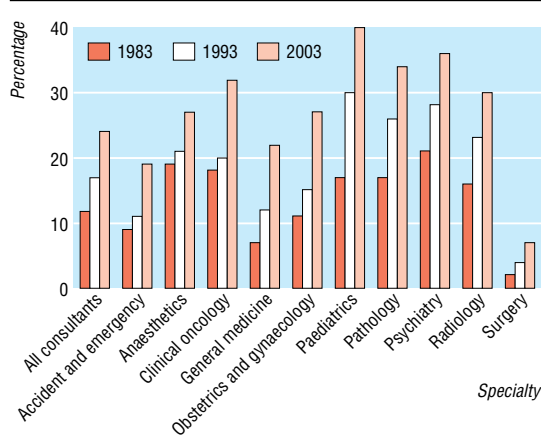


Fig 2 Proportion of female consultants by specialty

Views of women doctors

I recently conducted a series of five focus groups in a London hospital with women consultants and specialist registrars in their late 20s and 30s. I asked many of the questions asked in my earlier research, with particular reference to the work-life balance. I focus here on the views of consultants. The women came from a mixture of specialties and all had small children. Some had done flexible training; some were working full time and others part time. What were the biggest constraints on their careers and what stresses did they experience?

Stress at work has been consistently related to lack of control over the working environment.¹¹ But it was striking how these women consultants felt that they were actually “in control,” “calmer” at work than at home. The things that male consultants found particularly stressful—perceived loss of consultant autonomy, loss of control over their work environment, concern about targets, conflicts with managers, poor support services, and inefficient back-up systems¹²—paled into insignificance for the women. “I think you just factor that in as a normal background source of irritation,” one commented.

These women consultants stressed the importance of time management in their lives. All of them considered proximity to the workplace to be crucial. Certainly the stability of a fixed job in one place as a consultant and the removal of the geographical mobility required of most specialist registrars was a great relief.

The importance of role models or mentors for women doctors cannot be underestimated. Both consultants and specialist registrars spoke of the advantage of having people in the department who shared the stresses of juggling work and family, not only other women consultants. An anaesthetist spoke of her department being “Run by people who have other lives. It’s not just the surgeons and the anaesthetists, it’s the theatre staff, ward staff. It’s a whole department of people saying the operating session has to stop at half past five.”

Those who had done flexible training said they had been regarded as very desirable, not only because they were supernumerary but because they came with funding attached. But times (and funding) had changed, and they thought that it was much more difficult now for potential flexible trainees.

The women thought it better to start full time as a consultant and then negotiate to less than full time. They often dropped just one or two sessions, and they regretted the loss of time for developing services that resulted. Women registrars and consultants still had problems in some male dominated specialties.

One consultant had considered an academic career but had abandoned the idea. She had done a PhD at a prestigious teaching hospital and could have gone on to a senior lectureship, but had settled for a consultant post elsewhere: “I decided I would not be able to juggle everything—to be a good clinician, plus do the research, plus have a social life and a family life. I couldn’t do a senior lecturer job part time. I’d get kicked out.”

The problem of recruitment to academic medicine, which has been highlighted by the chief medical officer,¹³ seems likely to become more acute unless

women's needs can be accommodated in more flexible career pathways.¹⁴ Attention also needs to be paid to the particular importance of mentors and role models for women in academic medicine.^{13 15}

The consultants emphasised that women may have different career paths from men. This M shaped distribution of women's careers has been recognised for a long time: the peak in the early years, the dip in the middle, and then the potential for a peak in the later years. My earlier research showed clearly that women doctors did not drop out after childbirth, as many people had thought, but continued working, often part time in general practice or community health. There are far more opportunities for women now and their potential contribution in the second half of their careers should be fully exploited.

Adapting to change

The profile of the medical profession is changing—not only with increasing proportions of women doctors but also with increasing proportions of UK qualifiers from ethnic minorities. The days of the white male dominated medical profession are numbered. In 2003, among UK qualified doctors, white men accounted for 68% of consultants but only 33% of senior house officers and 29% of house officers.⁸ In 2002, white men accounted for 26% of entrants to UK medical schools.¹⁶ But does this matter? Great care should be taken before attributing any potential loss of professional status to the changing profile of the medical profession.

We need to take a fresh look at the ingredients of professional status. I don't believe that patients value women doctors any less than men doctors. Much more damage is likely to have been done to the status of the medical profession by costly public inquiries into professional misdemeanours, mostly resulting from actions by white male doctors, than by the failure of women doctors to flock into committees.

It is time to reconsider some of the entrenched values and attitudes that reinforce the traditional pecking order in medicine and remain a source of implicit discrimination against women. Should certain specialties be more highly regarded than others and remain largely male preserves? Why are all consultants

Summary points

The medical profession has been slow to adapt to the fact that women have accounted for over half of medical students for over 10 years.

Women still account for only just over a third of hospital doctors and general practitioners

Young women doctors find achieving a work-life balance stressful

Women doctors have much to offer in the second half of their careers and should not be prevented from achieving this by rigid career paths

Women should be better supported in academic medicine

expected to take on so many different duties, particularly if they want clinical excellence awards? Are there no measures of quality other than long hours, committee membership, and research papers?

Some progress has been made. The profession has realised that long hours and lengthy, unstructured training periods do not necessarily ensure a well equipped and well balanced workforce. But perhaps the most important recent change to benefit women doctors—the reduction in hours—has been imposed from outside the profession with the implementation of the European working time directive. There has been some belated recognition that the straight full time career path so engrained in the mindset of the medical hierarchy could be open to change. But suspicion remains of those who have more unconventional career paths or who have not reached a certain grade by a certain age. Let us hope that the government's plans for reform of postgraduate training will allow more flexibility.¹⁷

It is pointless to hanker after some golden age in which medical careers and working practices were organised in such a way that nobody who wanted to lead a "normal" life, whether male or female, could hope to reach the top of the profession. It was not a golden age and will never return. The most important thing for the medical profession to concentrate on now is how best to use the resources it has and will have in the foreseeable future. It should be a matter of great pride that so many brilliant young women are choosing to enhance the profession, and every effort should be made to throw out old fashioned practices and attitudes that inhibit the contribution they can make both in the early and later stages of their careers.

Contributors and sources: IA has conducted several research projects on doctors and their careers over the past 20 years, mostly commissioned and funded by the Department of Health. This paper is based on a longer paper presented to the annual conference of the Medical Women's Federation in November 2004.

Competing interests: None declared.

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Postgraduate training grades

Postgraduate training is designed to prepare doctors to become consultants or principals in general practice. The traditional training pathway is as set out below but is changing:

Pre-registration house officer—the first year of postgraduate training, leading to full registration with the General Medical Council.

Senior house officer—the next two years or more of general professional and basic specialist training

Specialist registrar—Higher training in a specialty, usually lasting 4-6 years, after which the doctor is eligible to apply for consultant posts

GP registrar—Final year of training for general practice, completing the three year vocational training

Staff grades and associate specialists—Doctors working at subconsultant level who are not currently in training

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Open label extension studies: research or marketing?

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Open label extension studies allow continued prescribing of unlicensed drugs after a randomised trial, but it is unclear whether patients or drug companies are benefiting the most

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Properly designed and conducted open label extension studies can provide rigorous information on long term safety and tolerability of potential new drugs. This in turn can benefit the licensing application for the drug by providing longer term data that would otherwise not be available until after the licence was approved. Nevertheless, the conduct of such studies raises several ethical and scientific concerns.^{1 2} As with any research method, there are good and bad examples. However, open label extension studies seem particularly prone to the pressures of marketing over good research methods and research ethics. We revisit some of these issues and argue that we need to change our approach to the ethical review of such studies.

Open label extension studies

Open label extension studies typically follow a double blind randomised placebo controlled trial of a new drug. At the end of the double blind phase, participants are invited to enrol in an extension study. The study will normally be longer than the randomised trial (two

years is not uncommon but they often continue until the drug is licensed). All participants in the extension study are given the study drug, and both they and the investigators know this. The objective is primarily to gather information about safety and tolerability of the new drug in long term, day to day use.

Use of open label studies after phase III trials is relatively common. In 2004, the multicentre research ethics committee for Wales reviewed three open label extension studies compared with 19 phase III studies of new drugs, a ratio of just over 6:1. However, a recent Medline search for studies between 2000 and 2004, produced only 86 open label studies but over 2000 phase III studies, a ratio of 23:1. This suggests that many open label studies are never published.

Issues of consent

The way that open label extension studies recruit raises several questions about informed consent. Participants are invited to join the extension study as soon as their involvement in the randomised controlled phase III study is finished. They do not know whether they have been taking active or placebo treatment, and investigators will not normally unblind the study at this point. Participants will thus base their decision on their previous study experience. Given that participants in either arm of the trial may have had positive or negative outcomes, their experience during the trial and their perception of the efficacy of the treatment they have received cannot be a sound basis on which to make such a judgment. In addition, as the results of the phase III study are unavailable, participants will be receiving a drug without the evidence that the treatment is any better than the standard treatment; it may potentially be worse.

The clinical picture of some participants may also have changed during the phase III trial. Participants may no longer meet the inclusion criteria or may no longer require treatment. At the conclusion of a trial participants are normally reviewed by their doctor. Enrolment in an extension study could result in



Participants in open label extension studies need more information

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ABSTRACT

In practice, part time clinical roles in hospital medicine have long been common, senior doctors taking on professional, managerial, or private practice commitments. 2 However, a larger cultural change will be required to make the establishment of stand alone part time consultant posts more acceptable.

FULL TEXT

EDITOR-Allen highlights the changing nature of the medical workforce. 1 This has significant implications for workforce planning and service delivery. For example, the wishes of a number of flexible trainees to continue part time working in the early consultant years means that more trainees (and therefore national training numbers) will be needed to fill consultant posts to deliver the whole time equivalents required. This applies particularly in specialties with a substantial proportion of flexible trainees, such as paediatrics, psychiatry, palliative medicine, general practice, and anaesthetics.

Many specialties are well suited to sessional or part time work, be it in the operating theatre, outpatient clinic, or laboratory. The new consultant contract should make it easier to design such working patterns. In practice, part time clinical roles in hospital medicine have long been common, senior doctors taking on professional, managerial, or private practice commitments. 2 However, a larger cultural change will be required to make the establishment of stand alone part time consultant posts more acceptable. With female consultants now forming a quarter of the consultant workforce-and rising-such arrangements may increasingly become the norm. Creative solutions could include two consultant colleagues job sharing, one with school age children undertaking proportionately more work in school terms, and one without, working more in school holidays, when they are unlikely to wish to take leave. This might also suit those with busy committee roles or external commitments in support of the NHS, which tend to fall within term times, and they could then contribute to clinical care predominantly during school holidays. Shift work should provide opportunities for families to cross cover childcare with day, evening, and night time work.

Part time consultant posts or reduced clinical commitments appeal not only to those with young children but also to those with caring responsibilities for older relatives and those approaching retirement. This may be one way to address some of the concerns about work life balance articulated clearly by hospital consultants. 3

Work patterns have changed in recent years for many reasons. Junior doctors work shorter hours. Junior doctors report unemployment, yet the UK seriously lacks senior doctors in comparison with other countries at similar stages of healthcare service health provision. Men and women in medicine increasingly state they want a personal and family life, and, like people in other occupations, doctors seek flexible training, employment, and career development compatible with the different stages in their lives.

Many patients rely on relatives to bring them to clinics; others are themselves at work in the day and prefer evening, Saturday morning, or appointments outside term time. And some doctors prefer to work at times when others in the family are able to provide care for their dependants.

If the investment made in the medical workforce is to be fully realised as benefit for patients then arrangements

for career planning and development and the conditions of work must be compatible with the life and work choices of doctors and the population they serve.

Footnote

Competing interests: SG is also a part time associate postgraduate dean in the Severn and Wessex Deanery with responsibility for flexible training, and past president of the Medical Women's Federation.

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DETAILS

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Rapid responses to BMJ 02 December 2006

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Let us now praise famous men, and our fathers that begat us. [1]

A speculative conversation in BMA House (17 November) led to a feasibility study investigating survival, among that unique population of distinguished professionals who merit an **Obituary in the BMJ**. This follows a series of studies on the occupational wellbeing of doctors. [2] Between 7 January and 18 November, **297 men and 49** women were described in the printed Journal, with their year of birth and death. Precise date of birth was not usually available, so estimated ages at death were between 32 – 106 years for men and 35 – 101 years for women, +/- one year. The initial hypothesis, based on observations about early retirement among doctors in primary care, [3] was that general practitioners would die at a younger age than people in other areas of practice.

Several classification systems for area of practice were tried. The simplest one that proved practical had these subgroups (based on the main career narrative of each obituary, not its heading): general practice, psychiatry, acute hospital, public health, medical science (this included some who never practiced clinically), complementary therapy, and a 'mixed' group of clinicians who worked simultaneously in primary care and hospital settings (who were analysed both with general practice or as a separate group).

Unlike the classic sample of Richard Doll, there were no significant differences in longevity found between general practitioners and other doctors. [4] A marginal difference could be observed between consultant psychiatrists and other secondary care doctors (mean difference 5.2 years, T-test, $p = 0.050$). The age at death appeared most different between the psychiatrists (mean 74.0 years, $n = 27$) and those professionals with the least direct patient contact, in public health (mean 83.3, $n = 17$) or medical science (mean 85.1, $n = 8$). Because the overall age distribution was skewed towards venerable individuals, these differences were confirmed with a non-parametric test (Mann-Whitney U, both $p = 0.034$). Other research has suggested that compared to other specialists, psychiatrists have a slightly raised mortality (RR 1.12). [5]

However, the main finding from this small study was unexpected. The mean age at death in obituaries of women was 72.7 years and of men was 79.3 years (T-test, unequal variance, $p = 0.011$, U-test, $p = 0.012$). In England as a whole, the latest report on the Department of Health website "Tackling health inequalities: Status report on the Programme for Action" suggests women live on average 4.5 years longer than men (80.7 vs 76.2 years).

Let us now praise distinguished women in medicine, who perhaps sacrifice 6.6 years compared to men of similar merit.

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Competing interests: This feasibility study was inspired by Sharon Davies at BMJ publishing.

Competing interests: No competing interests