Women doctors and their careers: what now?: Women contribute less than men to non-clinical care as general practitioners in Scotland

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Five futures for academic medicine

Future of academic medicine looks bleak

Editor—Four factors are responsible for the failure of academic medicine. The first is the research assessment exercise, which, surprisingly, is not discussed in the ICRAM scenarios outlined by Clark for the International Campaign to Revitalise Academic Medicine. The second is the inhibition of clinical research by the draconian regulations often inflicted by ethics committees. The third is the formidable problems faced by people wishing to work with animals. The last is the conflict of working for two masters—the universities and the NHS.

The scenarios have taken little account of previously successful models of clinical academic departments, which made important contributions in advancing medical science and promoting high educational standards. The research assessment exercise is inappropriate for craft specialties because it demeans staff with teaching and surgical skills, concentrating on research drawing in large funding.

Although scenario 4 draws attention to the issues of global academic partnerships, ICRAM failed to appreciate that this was the nature of clinical academic departments before the research assessment exercise was introduced. Fixation on research excellence, worthy as this may be, has forced academic staff to withdraw from essential external commitments.

Decisions need to be made urgently before attrition results in further damage. As mentioned by Davies in her commentary, the disappearance during the past four years of 42% of clinical lecturer posts has removed the seed corn of future leaders in academic medicine. Lecturers rest poorly with the seed corn of future leaders in academic medicine.

With the persistence of the exercise and the current governance of universities, a strong case exists for the creation of separate universities of health sciences that are not subject to inappropriate structures driving the destruction of academic medicine.

The scenarios give limited reassurance that the current crisis is understood, painting a global commercial picture while ignoring many of our current problems. Unless immediate corrective measures are taken to halt the erosion of academic medicine, it faces a bleak future. Patients will be the ones to suffer.

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Follow the money trail

Editor—I was intrigued by the five scenarios of the International Campaign to Revitalise Academic Medicine. Certainly, brainstorming over the future of academic medicine is a fascinating exercise. But, aside from revealing facets of the interaction of medicine in general with (global) society, it is sterile.

Academic medicine—meaning the entirety of academic institutions globally—is heterogeneous and will certainly evolve differently in different societies as a function of local issues and cultures. But, most importantly, in any given location it will evolve in response to its sources of revenue, which are quite varied.

In the large private universities of the United States major funding comes from research grants (federal, pharmaceutical, and philanthropic) and only a small fraction (5–10%) from student tuition. As donors’ budget priorities change, so will academic priorities, as will the direction of the academic enterprise.

Certainly, medical schools will remain committed to a basic curriculum of human biology and clinical experience. But they will do this by using faculty staff hired for other purposes (clinically remunerative procedures and grant generating enterprises) since tuition alone cannot reimburse the faculty satisfactorily.

So, if you wish to see academic medicine’s direction in any given situation, look upstream to see where the money is coming from, not downstream, into the babble of salon conversation.

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of a chosen disease were discovered so the indispensable role of research in changing practice and outcomes at the bedside will be recognised. Observations of clinicians at the bedside first resulted in the identification and treatment of disease. Thus clinicians too are researchers, albeit working in a different environment to "pure" academics—provided that their inputs are acknowledged and used.

Recognising, encouraging, and rewarding the contributions of clinicians to academic work should lead to better integration between the two disciplines in the future. Changing medical school curricula to acknowledge the importance of research to clinical work, and vice versa, is a step in the right direction.

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Wine presses of academia produce young wines that don't cellar well

Enfrot—Godlee writes that academic medicine lacks vision and leadership in relation to the report from the International campaign to Revitalise Academic Medicine.1 Universities are no longer intellectual arenas or places of scientific debate. Drug company money salts most depart- ments. Machines can analyse whatever DNA probe until a "significant" correlation is squeezed like grapes in a wine press. The next scientific meeting is only six months away; abstracts have to be in next week. You can't rush a robust red. The label is hardly away; abstracts have to be in next week. You

If you stay in a department long enough you end up with a chair—until death (viz the House of Lords), regardless of how stuffing and irrelevant the professorial output. Few competitors apply. It's jobs for the boys, and it is usually a foregone conclusion who gets the job.

We make the error of assuming an academic is the same as an intellectual. Intellectuals don't last long now in academia as they ask questions and challenge dogma. Our former great intellectuals would not have got into print for lack of P values, grants, and ethics committee approval. However, we need ideas to be discussed so that they can then go into the scientific melting pot. Scientific writing has stifling conventions. The casualties are style, humour, and the active voice. Homer would have died laughing. Dare anyone say "I" let alone "the wine dark sea."

We have become slaves to evidence based conventions. However, we so often hear statements such as "the data had a nearly significant trend to significance." The negative study is as a rarity. Gaudeamus igitur.

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Specialised professional research system of "pure" medical science is needed

Editor—Clark's discussion of the future of academic medicine is stimulating but misguided.1 Medical science policy should aim primarily to enhance therapeutic progress and reverse the decline in major, clinically relevant "breakthroughs" over recent decades.2,3 Current medical research mostly constitutes an "applied" science, aiming at steady, predictable advance by an accumulation of small improvements.1 But more radical and risky strategies are required to solve problems which are not yielding to established methods.4,5

We need a specialised research system of "pure" medical science, whose role would be to generate and critically evaluate ambitious and potentially important theories, techniques, treatments, and technologies. Pure science units might evolve from existing world class applied medical research institutions, but such units must have distinctive objectives, evaluation procedures, organisation, career paths, and funding arrangements.

Will it work? Perhaps: imaginative patrons in the funding foundations might be attracted by the prestige of helping to establish an elite new profession.

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Neonates must sometimes be allowed to die, but err in favour of life

Editor—Neonatal intensive care medicine and nursing are constantly improving because staff are trying to save increasingly difficult cases. Staff will inevitably attempt to save cases that turn out to be hopeless, and decisions will sometimes have to be made to allow the patient to die. Such decisions have to be seen as part of a process that eventually results in more lives being saved.


4 Charlton BG, Andrews P. Medical research funding may have over-expanded and be due for collapse. (Q J Med 2005;98:53-5.)


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"Speed networking" may be one way forward

Editor—One way for universities to revitalise academic medicine might be to look outward.1 Research takes money, and competition for funding is fierce. The chances of success are improved by demonstrating an expertise in both subject area and appropriate methods. Collaboration can be one way to achieve this, but how do you know with whom to collaborate? It's not just about the interests or the skills, of course: if successful you have to work with these people.

A recent approach we used was a modified form of "speed dating" to improve our collaborative outlook. The Academic Unit of Primary Health Care and the School for Policy Studies are active in research at the University of Bristol, but in different faculties. We were aware of some overlap in subject areas and methodological expertise, yet to date we have had little experience of working together. We devised "speed net- working" as an efficient means for members from each unit to meet and identify areas for possible future collaboration.

We introduced the groups to each other through brief oral presentations that gave an overview of the departments. Members from primary health care were then stationed at points around the room and, at three minute intervals, colleagues from policy studies were invited to rotate to each station. After 24 minutes all 16 participants had had the opportunity to meet and rapidly outline their skills and interests. Thereafter followed coffee to allow interested "pairs" to follow up their introductions in more detail.

Other means of networking exist, but so far as we are aware this is the first application of a populist approach to research. Feedback from participants was positive, and we suggest that other departments looking for research relationships speed network as an ice breaker to future collaboration.

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See pp 507-9

Dogmatic "pro-life" stances are therefore out of place. But what happens when there is a dispute between staff and parents? I try to teach students that they will inevitably make a certain amount of mistaken decisions during their careers. But if you are going to err, then err in favour of life. It must be extremely painful to have saved a life and wished later that you hadn't done so. But it must be more painful to have allowed someone to die and wished later that you had put in more effort to save him or her. I therefore try to convince my students that in neonatal intensive care (as in other situations where the patient cannot communicate) if the parents want you to let the baby die, and you think the baby is worth saving, you have to remember that the baby is not the parents' personal possession, like a car or a bicycle. The baby does not belong to anyone but is a full human being in its own right. So you have to save the baby, no matter what the parents say. If the staff think that the baby should be allowed to die, and the parents want you to keep on trying, then you have to keep on trying.

I have one reservation. Where "erring in favour of life" is the policy of neonatal intensive care unit, then much more work has to be done to improve social services, so that parents will not be sent home to situations that they cannot handle.

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Competing interests: None declared.

1 Deer C. Parents of disabled baby lose appeal against court order. BMJ 2005;331:472 (3 September)

Letters

Women doctors and their careers: what now?

The changing UK medical workforce's effect on planning and delivery of services

Editor—Allen highlights the changing nature of the medical workforce. 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. However, a larger cultural change will be required to make the establishment of shared or 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.

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 teaching, 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.

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Women contribute less than men to non-clinical care as general practitioners in Scotland

Editor—Allen is rightly optimistic about women's current and future contribution to medicine. She also rightly emphasises the combined impact of the feminisation of general practice and part time working, which has implications not only for the delivery of services but also for the development of the specialty.

The problem is probably worse than she portrays because the common definition of full time (36 h/week) is usually derived from government figures based on previous contract status. We conducted an anonymous survey in Scotland of all general practice principals and non-principals (now all called performers) in the summer of 2004 about current in-hours workload and anticipated workload over the next five years (response rate for principals 67.2% (2541/3783) and 65.2% (749/1149) for non-principals).

We found that women under 40 outnumber men in general practice, out-numbering them in all age groups in the Lothian region. Overall, men spent an average of 7.9 and women 6.7 sessions on in-hours clinical General Medical Service (GMS) activities. However, women declared as full time under the old contract still worked fewer hours than full time men (7.5 v 8.1 sessions, P < 0.01).

Allen's hope that women would contribute more time to work as they got older was partially supported by our research, but nevertheless in every age group women's average working hours were significantly fewer than men's.

The differential, however, is perhaps more worrying with regard to NHS and educationally related non-GMS activity (GP training, medical student teaching, administration, appraisal, special interest, research). Men spend more than half as much additional time as women in many of these areas (1.1 v 0.73 sessions weekly on average). Men and women were not significantly different only in medical student teaching and medical research (all the other areas P < 0.01). Although the proportion of time spent by women on these activities increased over the age of 40, it never reached parity with that of the men.

Given that most truly full time general practice doctors in Scotland are now over 45 and that they are predominantly male, a crisis is clearly looming not only for the delivery of general practice itself but also, perhaps more seriously, for the development of the specialty as a whole. Women will
have to become much more involved in future if the specialty is to thrive in Scotland in the next 20 years.

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Melanoma incidence has risen in Europe

Editor—Welch et al say that the increased incidence of cutaneous melanoma is a result of overdiagnosis because of increased diagnostic scrutiny, rather than an increase in the true occurrence. They observed that incidence rates of melanoma among American citizens aged 65 and older were strongly correlated with biopsy rates and that mortality from melanoma remained stable.

We wish to comment on this from a European perspective. Although increased biopsy rates have undoubtedly emerged and contributed to increased detection of melanomas, there are indications, at least in Europe, that part of the increase in melanoma incidence is true. Mortality due to melanoma in Europe was not stable, pointing to real increases in the incidence of melanoma.

In many European populations death rates from melanoma have been, at least up to 1997 and in the Netherlands also up to 2002 (figure), continuously and significantly increasing over time in all age categories, but especially among elderly men.

These increases affected young people (aged 25–49) in the magnitude of 2-3% per year in some north and west European countries and up to 8% in Spain. At older ages, more populations exhibited increases; in men above age 70 these varied between 2.7% (Netherlands) and 7.5% (Spain) yearly and in elderly women between 0.8% (Norway) and 7.7% (Spain).

Moreover, in many populations increases in incidence and mortality have been observed for up to five decades, which also argues in favour of at least part of the increases in melanoma incidence being real. For biopsy rates to cause the observed linear increases over time, they would have to have been increasing linearly for decades, which we find unlikely. When the observed increases in mortality from malignant melanoma in Europe, mainly among elderly men, are taken into account, part of the observed increases in melanoma incidence seems to be “real.”

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Government did not suppress health inequalities report

Editor—Shaw et al repeat claims that the government suppressed its health inequalities report. This is nonsense.

Tackling Health Inequalities, actively promoted and announced via a press release issued to 1300 journalists and media outlets, received widespread coverage, including stories in the national and regional press.

Professor Sir Michael Marmot, the report author, was extensively interviewed. We as the government can, therefore, hardly be accused of a hushed up release.

We are determined to reduce health inequalities. The report showed that we are moving in the right direction and highlighted the further work that needs to be done.

However, the report’s data dated back to 2003. Last November we published the Choosing Health White Paper aimed at improving health and tackling health inequalities. Health trainers are one of many initiatives in Choosing Health which will help narrow the inequalities gap by helping people to make healthier choices in their daily lives. Infant mortality, a key indicator of health inequalities, has fallen in the routine and manual group, as well as the total population. Government initiatives including Sure Start, better neonatal services, stop smoking services, and breastfeeding campaigns are all having an impact.

Progress is slower in more disadvantaged areas, which is why spearhead primary care trusts are piloting many of the key Choosing Health recommendations, including health trainers, in those areas.

Health inequalities are and will continue to be a government priority.

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I noted that two thirds of all Palestinian child fatalities had been caused by small arms fire (from relatively close range), in fully half of the victims to the head or upper torso—the sniper’s wound. My statement that “clearly, soldiers are routinely authorised to shoot to kill children in situations of minimal or no threat” has now been confirmed in emphatic fashion—the authority being Israeli soldiers who have committed these acts themselves.8 They refer to one of the cases I described.

Several dozen former soldiers calling themselves “Breaking the Silence” are exposing the cynicism of the Israeli defence forces’ mantra that everything possible is done to minimise the risk to Palestinian civilians. These soldiers testify that they were ordered in briefings to shoot to kill unarmed civilians, including children, even when there was no threat and in periods of calm. They were ordered to “fire at anything that moved” and were told “every person you see on the street, ‘kill him. And we would just do it.’” The attitude was “so kids got killed. For a soldier it means nothing.”

The desire to avenge Israeli casualties and inflict collective punishment was an important factor. In Gaza in May 2004, “the commanders said kill as many people as possible,” and there were standing orders to shoot anyone on a roof or balcony, whoever they were. One former soldier said this was why the Moghayer children (aged 16 and 13), collecting washing and feeding pigeons on the roof of their home, were shot. Israel’s defence forces claimed that they had been blown up by a roadside bomb, until journalists were shown the bodies in the morgue, each with a single bullet wound to the head. I mentioned this case in my BMJ article.

Can those who saw my paper as antisemitic lies face “Breaking the Silence”: Will the Jewish organisations that made heartfelt statements about the BMJ, amid calls for the acting editor to be censured or removed, apologise? And who will challenge the Israel Medical Association for its silence on the ongoing violations of the Geneva Convention I documented?9

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9 Israeli army’s shoot to kill policy

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9 Israeli army’s shoot to kill policy

References

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4 The attitude was “so kids got killed. For a soldier it means nothing.”