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.1 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.2

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,3 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 research assessment exercise as they hold trainee posts of limited tenure.

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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Competing interests: None declared.


Follow the money trail

Editor—I was intrigued by the five scenarios of the International Campaign to Revitalise Academic Medicine.1 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 hallowed 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 curriculums 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

Entor—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 departments. 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 recognisable. Observations of clinicians at the bedside will be indispensable role of research in changing the contributions of clinicians to academic work should lead to better integration between the two disciplines in the future. Changing medical school curriculums to acknowledge the importance of research to clinical work, and vice versa, is a step in the right direction.

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Women doctors and their careers: what now?

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

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

Competing interests: None declared.

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Frank J Leavitt

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

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

Letters

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 “errring 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.

The problem is probably worse than she portrays because the common definition of full time (>26 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% (2541/3785) and 65.2% (749/1149) for non-principals).

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 < 8.1 sessions, P < 0.01).

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.


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 vs. 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.

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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.

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Competing interests: None declared.
Foundation year for newly qualified doctors

A house officer writes

Editor—Although I sympathise to an extent with the views of the foundation programme’s organisers and the Modernising Medical Careers quango, I think that there are some big defects. This is based on my experience as working as a house officer.

Postgraduate training seems to have been hijacked by self-styled medical educators who come mainly from academia and have a different agenda from the many trained doctors and doctors in training who work on the coalface of clinical medicine.

In the reams of literature and hours of talks it seems that care for patients has been forgotten, with numerous assessments (with funny names) of topics and skills learnt at medical school and talk of audit and portfolios. I just want to do a good job for my patients, and that is what I have been eagerly waiting for since my finals.

I recognise that we need to have some sort of close supervision in the embryonic days of our medical careers, but we also need to provide a service, and we can learn by providing good clinical care with senior supervision to as many patients as we can. I and many colleagues believe that after six hard years at medical school we are becoming deskilled and disheartened. Is this what I went to medical school for?

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Nobody knows whether the foundation programme works

Editor—I am baffled how Hays can come up with an article where he claims that the pilots for the foundation years have worked.1 So far as I am aware nobody knows if it has worked, and nobody will know if it progresses to be successful until August 2007. Foundation year 1 started this year, but foundation year 2 is now in its second year as a pilot scheme and does not officially begin until August 2006. So what are doctors who have completed their foundation year 2 this year or next year meant to do? Where do they go from there?

They will not get entry on any specialist training rotation without the necessary qualifications or experience required. The supposed implementation of the new style specialist training for Modernising Medical Careers does not start until 2007, hence we have a lot of doctors in limbo who are looking for posts and are not able to find any posts as senior house officers.

All specialties are competitive, and nobody will want somebody with less experience and no higher diploma or degree to train as a specialist registrar in their scheme. Not even the royal colleges know what impact the foundation scheme and Modernising Medical Careers is going to have on training, so for Hays to suggest that it is successful is ludicrous. Much more information is required by doctors undertaking training as to what they should do in terms of attaining higher diplomas and experience.

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1 Hays R. Foundation programme for newly qualified doctors. BMJ 2005;331:465-6. (3 September.)

Will this development benefit overseas doctors?

Editor—The foundation programme brings a welcome change to the training system in the United Kingdom. Having passed the exams of the Professional and Linguistic Assessment Board (PLAB) in 2000, I worked in UK hospitals as a house officer for 12 months before being kicked out to another hospital and then another. Finally, after working in six different hospitals and obtaining membership of the Royal College of Physicians (MRCP), I got a post as a specialist registrar.

By this time I had completed the US medical licensing exams and moved to the United States. The training, which is similar to the foundation programme, includes rotating among different subspecialties. I was attached to one hospital, which created a special bond to serve this hospital. No major examinations are involved in residency. This helped me to concentrate on clinical work.

I hope the foundation system will start in every hospital in the UK. This will eliminate the unnecessary paperwork that junior doctors have to go through every six months or every year. This is especially true for overseas doctors who have to concentrate on obtaining a job and sorting out their visas rather than on caring for patients.

I hope that the UK learns from US residency programmes and starts a matching programme nationwide for foundation year trainees, to save manpower and resources. This could have a positive impact on patient care.

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1 Hays R. Foundation programme for newly qualified doctors. BMJ 2005;331:465-6. (3 September.)

GMC assessment of junior doctors’ competency is inadequate or inconsistent

Editor—In his article on the new UK foundation programme, Hays says that assessment will focus on practical aspects of medical work rather than examinations. An examination already exists, however, that is explicitly set to correspond with the level of knowledge expected of a doctor at the end of foundation year 1.

This is the Professional and Linguistic Assessment Board Test (PLAB), administered by the General Medical Council to assess whether international medical graduates have the ability to practise safely as senior house officers in UK hospitals.1 It takes the form of a written paper (part 1) and an objective, structured, clinical examination (part 2). Pass marks for the part 1 extended matching question (EMQ) examinations in 2004 ranged from 59.0% to 65.5% (Jo Mullin, GMC PLAB test section, personal communication, 2004).

We conducted an audit of UK graduates taking up senior house officer posts in accident and emergency medicine at a major London teaching hospital. A paper comprising 50 extended matching questions was derived from a popular PLAB revision aid2 and then edited by an experienced former PLAB examiner to confirm that it accurately reflected the standard of the PLAB examination. Twenty eight senior house officers sat the test in November 2004 and March 2005. Only four scored less than 60% (mean mark 64%, SD 11%) but, of these, two scored only 38% and 40%—well below the pass mark and more than 2 standard deviations below the mean.

How many doctors completing the foundation programme would be found wanting if tested by this benchmark? We think there is a strong case for a PLAB style examination to form part of the assessment process for both foundation years, thereby providing a level playing field for UK and international medical graduates. Alternatively, if examinations are no longer thought to be relevant, the PLAB assessment should be revised.

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1 Hays R. Foundation programme for newly qualified doctors. BMJ 2005;331:465-6. (3 September.)
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.1 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,698 and in elderly men among Melanoma incidence in Europe has 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.1

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,2 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.3 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 aushed 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 health inequalities, has fallen in the routine

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Short term outcomes lead to long term questions

Editor—Lavender et al add evidence to the debate about a randomised controlled trial comparing vaginal birth with caesarean surgery.1 However, we need to think even more widely, and more long term, about this possibility, as highlighted recently by the term breech trial. Researchers randomised
breeches to vaginal birth or caesarean and concluded, in the year 2000, that caesarean birth was safer. Virtually overnight, vaginal breech birth disappeared as an option for women worldwide.

Follow-up of children from the term breech trial at age 2, published in 2004, found that differences between groups had disappeared: vaginal breech birth was no more risky for offspring in the longer term.1 Several documents have identified that “clearly, soldiers are routinely authorising to shoot to kill children in situations of minimal or no threat” has now been confirmed in emphatic fashion—the author being Israeli soldiers who have committed these acts themselves.2 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” and the Will the Jewish organisations that made media statements about the BMJ, amid calls for the acting editor to be censured or apologised? And who will challenge the International Medical Association for its silence on the ongoing violations of the Geneva Convention I documented?2 3

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Jewish soldiers confirm the policy

Editor—My personal view last October on the Israeli army operations in the Palestinian territories occupied by Israel, attracted support as well as vilification on bmj.com.1

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 cases 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.2 They refer to one of the cases I described.

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1 Summerfield D: the pa...