
The female psychiatrist: professional, personal and social issues

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This is the final paper in the series of contributions to APT concerning gender and mental health (Bartlett & Hassell, 2001; Cremona & Etchegoyen, 2001; Kennedy, 2001; Kohen, 2001a,b; Ramsay et al, 2001).

In recent decades the professional life of the psychiatrist has become increasingly difficult. Several reports have highlighted the problems, which lead to disenchantment, low morale, sick leave, anxiety, depression and even early retirement (Ramirez *et al*, 1996; Kendell & Pearce, 1997; Pattani *et al*, 2001). Changes in the National Health Service (NHS), the difficulties in daily practices, the climate of litigation and the culture of blame have all contributed to an atmosphere where lack of empathy and appreciation has become the norm.

Holloway *et al* (2000) have discussed the stresses and difficulties that psychiatrists experience, the day-to-day demands, the regular adverse events and the clinical risks they have to face. It is obvious that role overload and the unrealistic service demands that lead to general demoralisation in the profession are similar for male and female psychiatrists. It is also true that the comprehensive range of support systems that could be deployed to deal with these stresses would be therapeutic to both male and female psychiatrists.

This paper concentrates on the specific problems that interfere with the well-being of female psychiatrists and the demoralisation process that leads to further disillusionment, alienation and potential morbidity (Box 1). We discuss minor psychiatric morbidity associated with lack of support, increased and unrealistic demands and difficulties in fulfilling the role of the psychiatrist. Financial problems,

issues around career structure and prospects, complaints and job stability are known to affect adversely the life of the psychiatrist. We hope that this paper, which considers career planning and flexible training and gives details on pensions and maternity rights, will start a healthy discussion and will lead to long-awaited changes.

Finances

A large amount of data has been collected on the finances of women doctors. In the US, Ness *et al*

Box 1 Professional and psychological facts about female psychiatrists

- They do not receive the same financial rewards (e.g. merit awards) as their male counterparts
- They are not equally represented in academic psychiatry
- They have lower professional status and hold proportionally higher numbers of staff grade posts
- In the USA, the ratio of complaints against female doctors is higher than against male colleagues
- Retirement because of ill health is higher
- They report poorer coping skills and more physical and emotional symptoms
- Women doctors are more likely to report stress, anxiety and depression

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(2000) have documented the persistent gender bias in doctors' salaries, with women earning on average 14% less than their male counterparts (Dial *et al.*, 1994). Even after adjusting for differences in hours worked, the investigators found the salary inequality of \$63 000 striking (Josefson, 2000).

In the UK, it has been documented that fewer women receive merit awards. Women are often forced to make personal choices, such as taking on family commitments, and professional choices, such as the choice of speciality and career breaks, that may eventually leave them behind in this hierarchical system and hinder them from receiving awards (Tait & Platt, 1995).

The latest merit awards announcement shows that women consultants, who make up 20.8% of the consultant population, received only 13.7% of the awards granted. The merit award system has been accused of being biased towards the male population by many pressure groups and organisations (Tait & Platt, 1995).

Career structure

There are several studies looking into the determinants of career structure and advancement of female doctors (Modena *et al.*, 1999).

Questionnaires and career-related data show that rigid and institutional approaches that did not cater for flexibility in training and working left women at the lower end of the career ladder.

Kastrup & Petersson (1986) analysed the job profiles of male and female psychiatrists: males were found to complete their training at a younger age than females. Among those aged 25–44, 29% of men but only 6% of women had reached the position of consultant. Women were in less-influential positions and took part in fewer organisational activities.

Goerg *et al.* (1999) show that gender-based constraints may be leading female psychiatrists to work shorter weeks and show less diversification in their clinical activities and to refer more frequently to the psychological model rather than the biological model.

Recent flexible arrangements available for women to pursue their careers and 'Opportunity 2000', launched in 1991 to help women achieve top jobs, have all improved the part-time working and training prospects for women but have not yet reached their ultimate goal of equal opportunities. Although half of all medical school intakes in the past decade have been women, the male:female consultant ratio is nowhere near 50:50 (Royal College of Psychiatrists, 1998).

Women consultants are still not well represented in academic psychiatry or in the medico-political establishment, but it is satisfactory to see that now this fact is well acknowledged (Anonymous, 2001).

Complaints

As a member of the American Psychiatric Association Ethics Committee, Mogul (1992) assessed the prevalence and nature of investigated ethics complaints against female psychiatrists and compared them with those against male psychiatrists. The most common complaints were of a sexual nature; issues of discourtesy and breach of confidentiality followed. A greater proportion of the complaints of sexual exploitation made against women were for homosexual involvement. Cultural power differentials between genders help to explain some of the data. It is unfortunate that we could not locate any data studying the nature, frequency and gender distribution of complaints against psychiatrists in the UK.

Changes in job stability

Organisational downsizing is known to have a negative effect on the health of employees. Kivimaki *et al.* (2000) explored the underlying mechanisms between downsizing and mental health and produced new information about the possible causal pathways. Changes in work characteristics and in social relationships and health-related behaviour were important. The ill effects of decreased levels of skills and the effects of less participation were stronger in women. These led to sickness absence and increased prevalence of regular smoking. The authors concluded that changes of that nature lead to increased morbidity in the workforce.

It is interesting to see the parallels between the changes in the NHS in recent decades and the increased dissatisfaction in the consultant body. There have been consultants who found it difficult to move into small community bases after long years in the large district general hospitals. There have been colleagues who found it impossible to leave the peer support of the large hospital for a base with the team in the community. The lack of peer support is a recognised emotional burden and known to add to perceived work stress (Swearingen, 1990).

Changes in the NHS have removed from consultants control over several clinical and medical issues and have forced them to deal with conflicting roles

and to carry responsibilities without the appropriate authority (Thompson, 1998).

Increasing bureaucracy and paperwork, together with the changing ethos and management of the NHS, have been reported as reasons for early retirement (Kendell & Pearce, 1997). Pattani *et al* (2001) examined the NHS pensions agency retirement forms of applicants who were granted retirement because of ill health. They found that 72% were female. The most common reasons for retirement because of ill health were musculoskeletal (49%), psychiatric (20%) and cardiovascular (11%). The human and financial cost of early retirement and possible effective interventions need to receive further attention. It is clear that the changes in the NHS have adversely affected the consultant body. Further research could yield the information necessary to improve the quality of professional life.

Stress and morbidity

All studies of the mental health of health care staff have indicated higher prevalence of stress than in the general population. This stress has been attributed to the demanding nature of the work, the general lack of support and the inadequacy of training in subjects such as communication and management skills.

It is well-known that stressful job conditions increase the rate of morbidity and that job distress is associated with low functional health. Cheng *et al* (2000) have shown prospectively that low control rates at work predicted decline in mental health in women.

The evidence of stress and psychological symptoms in hospital consultants and other medical professionals have been examined by many: 20–40% of senior doctors had signs of stress in response to pressure and demands in the workplace (Caplan, 1994; Blenkin *et al*, 1995; Agius *et al*, 1996). Deary *et al* (1996) wrote that psychiatrists reported higher work-related emotional exhaustion and higher rates of severe depression than consultants in other specialities.

The effects of stress in the workplace, work satisfaction and burn-out were studied by Ramirez *et al* (1996). The estimated prevalence of psychiatric morbidity was 27%. Several sources of stress were associated with both burn-out and psychiatric morbidity. Work overload, poorly managed and poorly resourced posts, poor relationship with demanding patients, relatives and staff, low professional status and poor esteem all have been associated with increased stress. Burn-out was more

prevalent in consultants who felt insufficiently trained in communication and management skills.

Weinberg & Creed (2000) studied stress and psychiatric disorders in hospital staff and concluded that even after the effects of personal vulnerability to psychiatric disorder and ongoing social stress outside of work were taken into account, stressful situations at work contributed to anxiety and depressive disorders. They advised that organisational attempts to reduce work stress will help to reduce the prevalence of anxiety and depression. Decrease in conflicts between managerial and clinical roles would also help.

Guthrie *et al* (1999) compared sources of stress, psychological distress and burn-out in psychiatrists and suggested that factors such as safer environments and better interpersonal relationships and work environment could improve the life of the quarter of psychiatrists who scored above threshold in the self-reported questionnaire. They did not find a difference between male and female psychiatrists.

However, Rathod *et al* (2000), who also explored stress experienced by psychiatrists, found that younger groups and female doctors were more likely to report stress, anxiety and depression. Female psychiatrists in the Wessex region reported poorer coping skills and scored higher for physical and emotional symptoms.

Cheng *et al* (2000) examined prospectively the relationship between psychosocial work characteristics and changes in health-related quality of life over 4 years in a cohort of working women in the US. They concluded that adverse psychosocial work conditions were important predictors of poor functional status and its decline over time. Low work-related social support was associated with poor health status. Women with low job control, high job demands and low work-related social support had the greatest functional decline over time.

Wall *et al* (1997) studied minor psychiatric morbidity in a large sample of NHS employees. They found women doctors (36%) had higher rates of morbidity compared with their male colleagues (24%) and other staff (male nurses: 30%; female nurses: 29%) working in professions allied to medicine. General Health Questionnaire (GHQ-12; Goldberg, 1972) case rates for men and women were consistent across all workplaces, implicating occupational rather than organisational factors as the cause of distress.

Frank *et al* (2001) used data from the Women Physicians' Health Study, a large US questionnaire-based survey conducted in 1993–1994, to compare characteristics of female psychiatrists with those of other female physicians. They found that female psychiatrists had poorer health, were more likely to be current or ex-smokers and were more likely to

report personal histories of various psychiatric disorders. Hawton *et al* (2001) found that, unlike the general population, among NHS doctors the risk of suicide is higher for women. The study looked at 223 suicides by doctors over a period of 16 years and confirmed the high suicide rate for women doctors. The excess risk of suicide in female doctors highlights the need to understand and manage stress and mental health issues in female doctors more effectively.

There are several ways of increasing job satisfaction and putting in place a reward system that will improve the career prospects and personal life of female psychiatrists. It is foreseeable that more opportunities in flexible training and part-time working, well-established maternity rights and improved pension benefits could improve the professional life of female psychiatrists.

Career planning and flexible training

A little over 50% of medical graduates in Britain are women and of this group about 50% would like to work or train part-time at some point in their careers (Allen, 1994). A questionnaire study of female medical graduates from Yale (Potee *et al*, 1999) showed that 82% of those aged over 40 were mothers. Female physicians without children were more likely to be in surgical specialities, less likely to be in primary care and more likely to work full-time than were their female colleagues with children.

Fifty per cent of the 7206 psychiatrists in England are women but only 32% of consultant psychiatrists are female (NHS Executive, 1999). They form 51% of the staff grade, 39% of associate specialists and 37% of clinical assistants, suggesting some overrepresentation in the non-consultant grades. However, women now hold 51% of registrar posts, which may reflect the increasing popularity of psychiatry with women trainees. There are variations within the psychiatric specialities, with child and adolescent psychiatry and psychotherapy being particularly popular.

Flexible training (flexible is the preferred term for part-time; NHS Management Executive, 1993) is available to both men and women with well-founded personal reasons, although women still predominate and childcare is the most common reason. Flexible training is obtained by approaching the programme director of a senior house officer or specialist registrar scheme to devise a plan of training that will meet with the Royal College of Psychiatrists' approval and then approaching the postgraduate

dean's office for funding. Currently postgraduate deans fund 100% of flexible trainees' basic salaries, with on-call payments made by employing trusts. Funding, however, may be scarce in some deaneries (Clay, 1998).

A UK survey in the Thames region (Herzberg & Goldberg, 1999) found that 17% of all psychiatric trainees were training flexibly. This cohort performed better in the MRCPsych examinations than the national average, showing that flexible trainees are of at least comparable standard to full-time trainees. Of this cohort, 49% intended to become child and adolescent psychiatrists. The authors also reflected on the success of the scheme, which has led to increased demand for flexible training. They believed that this could be met financially only by increasing the use of job-share arrangements funded from existing budgets, rather than entirely by 100% deanery-funded supernumerary posts.

However, job-share does have its dangers, for example if trainees are expected to find their own partners, or to share their study-leave time and budgets (Garrard, 1999). The Women in Psychiatry Special Interest Group (WiPSIG) of the Royal College of Psychiatrists considers it important that study leave is not shared *pro rata* (Etchegoyen, 2000) because all trainees must be equally trained. In the North Thames region, the Associate Dean for Flexible Training provides funding for an extra 'handover' session for job-share trainees, and study-leave entitlements are the same for all trainees. Flexible trainees are expected to job-share only where their interests and geographical location coincides and they may revert to individual flexible posts at a later stage.

The decision to train flexibly or to combine motherhood with full-time working can be difficult and this paper can only summarise some of the factors involved in choosing which option to pursue.

The greatest advantage of working flexibly is obviously having more time to spend with one's children and having greater flexibility to ensure attendance at school events. This advantage can persist even as the children get older, allowing greater supervision of out-of-school activities and homework. It will also be easier to build up supportive networks with other mothers to cover the inevitable crises caused by sickness of either the child or the paid carer. Paradoxically, it may be easier to work full-time when children are very young, because they are less able to give well-argued reasons why they prefer certain arrangements and full-time professional care is easier to arrange. It can be more difficult to organise when the children go to school and have a large number of after-school activities.

The main disadvantage is obviously having less money. It should be remembered that working

part-time will also affect one's pension income, although this has been improved for some by the recent ruling on mental health officer (MHO) status. Other disadvantages are the prolonged period of training, with inevitably slower progress towards consultant status and the danger of feeling marginalised or losing status in some posts. Those working part-time need to be aware of the risk of working well beyond the contracted hours. It is generally thought that time management is easier when working full days, and half days are best avoided.

Maternity rights and pensions

Maternity rights and pensions affect quality of life and job satisfaction. It is important to think of them together with career structure, job security and the causes of morbidity and early retirement for the female psychiatrist.

Maternity rights

There is seldom a totally right time in a busy career to have children but like everything else this decision will repay some forethought and planning. Factors to consider include how easy (or difficult) it will be to combine motherhood with on-call duties and studying for the MRCPsych examination: perhaps it would be easier to wait until specialist registrar or consultant grade? Personal circumstances vary and other issues to consider are how much others, such as a partner or family, can offer support or whether one will be largely coping alone. It is difficult to envisage a totally different lifestyle and it is useful to talk to people who have had children at a similar stage in their careers. This may sound rather clinical for such an emotional and personal decision, but thinking ahead can make life easier in the long run.

Timing a maternity break can have financial consequences because NHS doctors need 12 months' continuous service for full maternity leave entitlements. This is counted back from the beginning of the 11th week before the expected week of confinement. There are complex rules as to what constitutes a break in service but employment can be with any NHS trust and some periods spent in general practice locums, voluntary service overseas or with an honorary NHS contract are allowed. The British Medical Association (BMA) has its own thorough guidance notes (BMA, 1999, 2000) and it also provides the Department of Trade and Industry's guide (Department of Trade and Industry, 2000). It

is worth obtaining these well in advance, especially if one has had non-NHS employers, for example a university or a private hospital.

In the NHS, maternity entitlements are governed by General Whitley Council Agreements and are usually more generous than the statutory provisions. Doctors holding university contracts will be subject to a university benefit scheme or, failing that, to statutory benefits, but are not covered by the General Whitley Council Agreements. It is particularly important for those taking university contracts to have an NHS honorary contract wherever possible. Otherwise, if a pregnancy occurs on return to an NHS post, it is possible that no benefits may be payable, owing to inadequate length of service.

Provided that an NHS doctor has 1 years' continuous service and declares an intention to return to work she will get 18 weeks' paid leave; the first 8 weeks will be on full pay and the next 10 weeks on half pay. Part of this (currently £60.20) is paid by the state as either statutory maternity pay (SMP) or maternity allowance. In addition there is an entitlement to unpaid leave, up to a total of 52 weeks of paid and unpaid leave combined. This only applies if the contract of employment does not expire within that time. Doctors with less than 1 years' continuous service who plan to return to work are entitled to a maximum of 18 weeks' unpaid leave. Part-time doctors who qualify for paid sick leave are entitled to maternity leave on the same basis and criteria as full-timers.

Doctors not intending to return to work who have 26 weeks' service with the same NHS employer by the 15th week before expected confinement get 6 weeks at 9/10 full pay and 12 weeks of SMP. Failure to return to work after declaring an intention to do so renders the doctor liable to repay maternity pay beyond the statutory entitlement. It is not necessary to return to work with the same employing authority/trust, but to avoid repayment the doctor must inform the previous employer of the new appointment.

Superannuation continues to be payable throughout paid and unpaid maternity leave unless a doctor is not returning to work and chooses not to pay contributions during unpaid leave.

The BMA (1999) guidelines also cover sickness absence during pregnancy, health and safety issues that may necessitate alternative employment, and issues around returning to work. They quote the General Whitley Council that 'authorities should, wherever possible, meet the expectation of women wanting... more flexible working arrangements' (section 2.6.2, p. 10). Doctors on planned rotations have a right to an extension of the original contract to enable completion of the agreed training programme.

From a training perspective, 3 months of maternity leave count towards training at specialist registrar level but leave beyond 3 months will put back the certificate of completion of specialist training (CCST) accordingly. Postgraduate deans also have flexibility to extend the 6-month 'period of grace' at the end of specialist registrar training in exceptional circumstances (e.g. where delivery coincides with the time for applying for consultant posts).

A final point is that it is worth writing to one's defence organisation as it will often suspend or reduce payments during maternity leave without jeopardising cover for past or future claims.

Pensions

This may not seem like the most exciting topic in the early years of a woman psychiatrist's career, but it deserves serious attention at all career stages.

What follows is only a brief summary of some of the more pertinent issues, including the recent employment tribunal victory to reinstate MHO status for part-time women psychiatrists (*Khalid H. Abbood and Others v. the Secretary of State for Health*, 2001). The BMA's guidance notes on the NHS pension scheme (Box 2) are available from local BMA officers and are well-worth reading. More detailed advice can be obtained by writing to the relevant pension authority (Box 3).

These bodies can provide a full service record for individual doctors and an estimate of the pension likely to be received. This can take some time to produce and the BMA warns that they may be under considerable pressure at present dealing with the MHO cases. The BMA Superannuation Department can also handle individual queries on behalf of members.

An NHS pension is based on contributions of 6% of superannuable income, which attract full tax relief. The pension is calculated using the formula:

$$\frac{\text{Years of service}}{80} \times \text{pensionable salary}$$

to a maximum of 45/80ths, plus a tax-free lump sum of normally three times the pension.

Pensionable salary is the notional whole-time salary of the position, based on the best of the last 3 years of service. This is the case even for part-time doctors. Years of service are actual years when service is whole time; any part-time service is scaled down to its whole-time equivalent. Thus, for example, it would take 11 years as a 10/11 maximum part-time consultant to achieve 10 years of pensionable service. It follows, therefore, that changing from part-time to full-time for the year or two before retirement has only a limited effect on pension.

The NHS pension, being index-linked, is a valuable asset and the BMA guidance notes strongly

Box 2 British Medical Association guidance notes of special interest to psychiatrists

The following are produced by the BMA Superannuation Department:

A General Guide
Salaried Doctors
Improving Pension and Lump Sum Benefits
Pensions for the Newly Qualified
Early Retirement (Including Redundancy)
Leaving the NHS and Pension Benefits
Why Doctors Should Not Opt Out
Injury Benefits

advise doctors not to opt out to join a private scheme. If a doctor leaves the NHS pension scheme with less than 2 years of service, a refund of contributions is payable. This is poor value, as the refund is taxed and a partial repayment of national insurance contributions must be made. The BMA gives guidance on how to avoid a disqualifying break. It also gives advice to doctors who move out of NHS service after 2 years as to whether to transfer benefits in the NHS scheme or leave the accrued benefits from the NHS scheme. This may be particularly important for women, who can have more varied career paths owing to family responsibilities.

One of the most valuable benefits for psychiatrists in the NHS scheme is MHO status. Every year of

Box 3 Pension authorities

NHS Pensions Agency
 Hesketh House
 200-220 Broadway
 Fleetwood
 Lancashire FY7 8LG
 Tel: 01253 774774

Scottish Public Pensions Agency
 St Margaret's House
 151 London Road
 Edinburgh EH8 7TG
 Tel: 0131 244 3585 or 0131 556 8400

Health & Personal Social Services
 Superannuation Branch (HRD 6)
 Waterside House
 75 Duke Street
 Waterside
 Londonderry BT47 6FP
 Tel: 028 71 319 000

service after 20 years as an MHO counts as 2 years for pension purposes, allowing retirement at 55 on a 40-year-equivalent pension or at 58 on a 45-year pension. The downside of this, however, is that it is detrimental for an MHO to take voluntary early retirement before 55. The BMA guidance gives an example of an MHO retiring at 54 receiving only 71.6% of accumulated pension, whereas by waiting to 55 a full 100% pension could be achieved.

For new entrants to psychiatry MHO status was withdrawn on 6 March 1995 in England and Wales and on 1 April 1995 in Scotland and Northern Ireland.

Prior to the recent legal proceedings it was necessary to be a whole-time or maximum part-time specialist who spent the whole or substantially the whole of that time caring for people with mental illness. It is possible to give up 2 notional half days for management or academic work and retain MHO status but the BMA advised doctors to check in advance whether a change in work pattern would endanger MHO status.

The current position has changed following a decision by the Birmingham Employment Tribunal in favour of three test cases taken by the BMA on behalf of part-time women psychiatrists (*Khalid H. Abbood and Others v. the Secretary of State for Health*, 2001). The Secretary of State conceded that MHO rules are indirectly discriminatory against women because they exclude part-time doctors and has withdrawn an appeal against the verdict. Following this, part-time service may now be counted back to 8 April 1976. Also, the 20 years after which doubling occurs will be based on calendar service, not *pro rata*, as originally proposed by the Secretary of State. This is very beneficial to many women psychiatrists but there are some further issues to resolve. A claim will still fail if it is not made within 6 months of leaving NHS service and therefore doctors who have already retired may lose out. There has been a decision by the House of Lords in a related case (*Preston v. Wolverhampton Health Care NHS Trust*, 2001), which helped decide this matter. The Pensions Agency has written to everyone who has already filed a claim (omitting those affected by the Preston case) to confirm and agree their service history.

One remaining area where women doctors' families are still disadvantaged by the NHS pension scheme is with respect to widowers' pensions. These are only payable in respect of the woman doctor's service since 6 April 1988. The only exceptions to this are where a female doctor's husband is dependent owing to permanent illness, has been nominated as such and accepted by the scheme, or where the woman doctor opted to buy extra cover in 1988/1989.

Finally, it is important to note that one disadvantage of the NHS pension scheme for men and women alike is that remarriage or cohabitation by the widow/widower leads to withdrawal of the pension unless severe financial hardship would result.

Conclusion

In spite of all the changes and reorganisation taking place in the NHS, the professional lives of male and, specifically, female psychiatrists would benefit from further organisational and structural improvements (Box 4).

Recognition of the difficulties faced by female psychiatrists who have unresolved personal, social and professional issues will lead to a happier and more productive workforce.

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Box 4 Ways of improving the life of the female psychiatrist

- More evidence-based research and information on the reasons for inequalities in awards and in academic life would inform better solutions
- Further research into the specific reasons for higher prevalence of stress, its contribution to anxiety and depression and other psychiatric morbidity is necessary.
- Determinants of job satisfaction and career structure should be reviewed and results should be widely publicised
- Flexible training and part-time posts should be made widely available
- Women should be encouraged to contribute to the professional life of the department and should be consciously included in the decision-making process
- Maintaining and improving established maternity rights and modern and realistic pension benefits

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