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# A Feminist Approach to General Practice

MAGGIE EISNER MAUREEN WRIGHT

## About the Authors

### Maureen Wright

*I would not have become a doctor without the support of my childhood GP. When I was eight, I was talking to him about my ambition to become a nurse and he said, 'Why not be a doctor? You'll enjoy it more.'*

*I found medical training an isolating experience, not only because I am a woman, but also because, unlike most medical students, I come from a non-professional, lower-middle-class family. When I qualified, my first reaction was relief that I now had the means to support myself and any children that I might have – the first time that I had consciously seen this as a motive for my choice.*

*After qualification, I dealt with my ambivalence towards medicine by spending six months working the hundred-hour week of a junior hospital doctor followed by six months living off my savings and forgetting I was a doctor. By then it was the mid-1970s: I was living in a large squat in London, going to my first women's meetings and becoming involved in community politics.*

*I became a GP sooner than I planned: I went to help at a collective practice in London for six weeks and stayed for four years. Having learned general practice within an unconventional setting, I am now struggling to become effective in a conventional practice. I work in a long-established health centre practice in Bristol with three full-time male partners. It's a typical 'part-time lady doctor job' and its limitations reflect the reality of being a single woman with two small children (aged six and three) as well as being a GP.*

### Maggie Eisner

*I cannot imagine a job which I would enjoy more than being a GP. My mother, a doctor, encouraged me to study medicine because she viewed it as both useful*

*to society and a sensible career offering secure employment and financial independence. I chose general practice to escape the impersonal, hierarchical hospital world, and so that I could be involved with a wide variety of people, health problems and situations, following people's changing lives over long periods.*

*I spent four years dividing my time between part-time jobs in two contrasting South London practices: one, in an inner-city area, was a conventional group practice dominated by the senior partner; the other was run as a collective, based on socialist and feminist ideas.*

*During this period, there were two major outside influences on my work. The Politics of Health Group helped me to understand how social and political factors are overwhelmingly important in health. An evening course at the Pellin Therapy Centre helped me with my personal development and filled a big gap in my medical training: I learned some invaluable practical ways to help other people with emotional and social difficulties.*

*I now work full-time in Shipley, Yorkshire, in a Health Centre where there are three separate practices. My predecessor was an elderly man who had practised single-handed; I took over his practice on the same basis, but was joined by a partner after six months. I have no children, and would not have considered even six months' single-handed practice if I had.*

Writing together

*We have been friends for at least ten years, and used to work together. We now live 200 miles apart and have enjoyed having an excuse to spend weekends writing together. After planning the chapter, we wrote separate versions which we then merged. Fortunately we agreed about what we wanted to say, so have been able to use 'we' throughout the main text. We have included some anecdotes from our individual experiences, and these are printed in small type.*

## THE CONTEXT OF OUR WORK

### Background information

General practice occupies a peculiar position in the Health Service; this section provides some background information to help readers to make sense of what follows.

GPs are not employees of the NHS. Each practice is a small business run by the doctors, who have a contract with the Family Practitioner Committee to provide medical services for the people on their list of patients. We are paid an allowance for running the practice, an annual fee per patient, and additional fees for particular services such as maternity care and contraception. Our total income is meant to cover both our salaries and the expenses of



running the practice – in other words, as long as we provide the basic services, we can choose how to spend the money, as well as choosing our own working hours, staff and premises (which we may own, or rent either privately or, in the case of Health Centres, from the Health Authority).

This means that the service someone gets from a GP will depend on that doctor's priorities, and partly explains why the standard of general practice is so variable. It also means that the state has less direct control over GPs than over the doctors it employs directly, who work in hospitals or in community clinics. And as bosses of small businesses, we are also the employers of the receptionists, secretaries and practice nurses we work with (though not of district nurses, health visitors or midwives, who are NHS employees).

GPs can choose to work alone, but most now work in partnerships or larger groups. Single-handed practice provides a very personal service for the patients, but a doctor working alone can usually offer a narrower range of services than a group practice; the doctor often also becomes isolated and idiosyncratic. In a group practice, the doctors may be equal partners and take equal shares of responsibility, work and money, or there may be a hierarchy among them, with a senior partner, and perhaps one or more part-time partners with limited responsibility. The latter are usually women.

The traditional image of the GP as paternalistic, authoritarian and working in isolation has been changing in recent years. The progressive face of general practice is represented by the Royal College of General Practitioners, a body set up along the lines of those governing and setting standards in other medical specialities such as surgery. It was instrumental in developing specialised training for newly qualified doctors wishing to become GPs, and this is now compulsory. The training schemes vary in different areas of the country but all consists of two years' hospital training and a year's apprenticeship with an experienced GP 'trainer'. Throughout, trainees may attend a half-day release course which provides a forum for discussion of problems and issues in general practice, and often some training in counselling and interpersonal skills, which are covered very inadequately at medical school. Almost 50 per cent of GP trainees are now women, but the vast majority of trainers are men.

Some of the ideas in general practice training have considerable appeal: for example, trainees are taught to make diagnoses in

every case in 'physical, psychological and social terms'. But women sometimes complain that this approach leads doctors to over-emphasise psychological and social factors in their illnesses. And the Royal College always sees GPs as family doctors; the traditional role of women in society is rarely questioned.

GPs are now seen as specialists, and it is recognised that our relationships with people who consult us are different from those of hospital doctors. Our contact is more intimate and longer-term and our work is much more about caring and reassurance, and less about medical diagnosis and treatment, than most people think.

> My own trainer once said to me 'I think our role is to be the patient's friend'. John Berger's book *A Fortunate Man* (1976) also gives an insight into the close relationships involved in good traditional general practice.

Despite the existence of an influential liberal current, the majority of general practitioners are extremely conservative. For example, 'lady doctors' are not expected to wear trousers at work, and even reading *The Guardian* is enough to earn us the reputation of dangerous radicalism. Our personal lives are assumed to be very conventional indeed:

> I was recently chatting to one of the other Health Centre GPs, who knows I am not married, about a visit to the theatre. When I said 'and we had a drink in the interval', he responded with 'Oh! You said 'we' – are you engaged?'

## The basic contradiction

Becoming a feminist and a GP has been, for both of us, a process of putting together brief flashes of insight and puzzling contradictions which have occurred at intervals ever since we first thought of becoming doctors. We have only learned as we went along that the things which attracted us to general practice – autonomy, a relative lack of a hierarchical institution, long-term relationships with many different people – were also the symptoms and results of the enormous privilege and power enjoyed by GPs: we have a lot more money, status and independence than most women. Our feminism has developed from a simple attempt to have straightforward, supportive and honest relationships with the women with whom we work, to include a much more complex understanding of the power relations in our male-dominated, class-ridden society, where doctors (and we must include ourselves) represent a significant area of control over women's lives.



While we were planning this chapter, we spent most of our time discussing the anomaly of being both a feminist and a privileged professional. A useful article by Mary Howell (1979) lists four areas in which the professionalism we absorb with our medical training is in conflict with feminist values:

1. Professionals learn to be arrogant and disrespectful towards people assumed to be less important than ourselves (eg. patients, receptionists, nurses).
2. It is assumed that as professionals, we deserve our privileges (eg. our high incomes, which enable us to pay for other women to clean our houses).
3. Professionals believe that the knowledge and skill we have acquired entitle us to exert control over other people's lives. This also implies keeping our knowledge secret and mysterious.
4. Professionalism defines what is important, valid and scientific (eg. which therapies are acceptable and which 'fringe'; which patients have 'real' diseases and which are wasting the doctor's valuable time).

Trying to get our brains (and especially our consciences) around these contradictions could paralyse us and make it impossible to work at all. Ignoring the contradictions is impossible unless we stop being either feminists or doctors. In our day to day work we inevitably make compromises which make us feel either that we are not being good feminists or that we are not being good doctors. It is easy to feel caught between criticisms from both sides, and end up hurt and vulnerable, or angry and resentful.

So what are we trying to do as feminist GPs? We want to be responsible to the people who come to us for medical help, not a part of the system which oppresses them. We would like to feel we are helping women to take more control over their health, as part of taking more control over their lives. We do not see health as an end in itself, but as a means to a life in which one has the chance to fufil one's potential. We want this for everyone, but as feminists we feel a special responsibility towards women.

## Relationships with our fellow-workers

Doctors are notorious for acting in an authoritarian, high-handed way with receptionists, nurses, midwives and other health workers seen as their subordinates.

We need to find ways to counteract our training and learn to respect other health workers as equals, paying constant attention to appreciating their skills, the personal qualities they bring to their work, and the particular problems of their position.

'Progressive' modern general practice emphasises the primary health care team consisting of GPs, health visitors, community nurses, midwives and perhaps social workers (all professionals – receptionists are not even mentioned). Unfortunately the reality is often a hierarchy with GPs at the top, expecting the other members of the team to provide 'handmaiden' support like that received by their hospital colleagues. GPs often talk about the team approach in terms of 'delegating' and reducing their own workload, rather than as a way of enriching everybody's working life and offering a better service. For example, they sometimes query whether a practice nurse could be 'trusted' to take cervical smears, a procedure which is traditionally carried out by doctors. Such a hierarchical view of working relationships obscures the enormous amount the doctors learn from others: knowledge flows up the power pyramid. Many individual GPs do acknowledge this, but it is not recognised in the structure of the team.

In general practice, the doctor is often the employer of the receptionists and possibly other staff. How can we develop democratic working relationships in such a hierarchical structure? We cannot be equal with someone whom we have the power to hire and fire. The present structure of general practice leaves us no choice about this position – we are the employers, and have a responsibility to be good ones. We also need to appreciate that the receptionists are aware of their position as employees.

> Although in our practice I think we all feel like friends, I sometimes notice one of the receptionists looks anxious if I suggest we should have a practice meeting. Her previous experience as an employee leads her to expect a meeting to mean a telling-off from her employer, rather than an opportunity for us all to discuss things as equals.

A receptionist's job is a balancing act between the requirements of the patients and those of the doctor. If receptionists can get close to patients, people benefit from their help and this makes their work more satisfying, but the physical structure of their working environment often makes this impossible. It is hard to make a fruitful relationship through a shatterproof glass partition in a crowded waiting room. The patients may feel that their needs are



overwhelmingly urgent and see the receptionist as an irritating barrier between themselves and the doctor; the receptionist must respond to those needs and minimise the irritation while also keeping the doctor happy: this may mean obeying a doctor whom she fears, protecting a tired, overworked doctor of whom she is fond, or even trying to respond to conflicting instructions from different doctors.

> A few months ago, my partner and I appointed two new receptionists; recently they both told me that when they first started, they were more worried about when to bring the doctors their tea than about how to deal with an anxious member of the public or a medical emergency.

Yet receptionists get almost no recognition or support – even basic training is a recent innovation, and few of them have access to it. It is a job where the responsibility is huge, but the power and freedom of action to deal with the responsibility are negligible.

As feminists, our aim is to work on an equal basis with other members of the team – but respecting their skills does not just mean 'You know what you're doing: just get on and do it' because we also have a responsibility to give them support. On the other hand, our feminist position cannot allow us to support other women workers uncritically: it is very difficult for a feminist to work with, for example, a health visitor or midwife who is prejudiced and patronising towards unsupported mothers. If we criticise our colleagues in situations like this, we must try to do it in a sisterly and constructive way, but be aware that we are likely to be seen as exercising our authority as doctors, and resented for it.

As well as trying to establish good relationships on the individual level, we believe it is important to support other women health workers as a group. The health service trades unions have many shortcomings, mirroring some of the faults of the NHS in their hierarchical organisation, with a majority of women at the bottom and men at the top, and in their narrow definition of health and health care. The relative isolation of general practice (even in health centres) can make trades union activity seem irrelevant, and many of the health workers in primary care are not unionised. But the unions do represent the most unified force for defence of the NHS and the jobs of its workers, and perhaps even for progressive changes within it; the women in the health unions deserve the support of feminist doctors.

## Sexism in the medical profession

Within the profession the problems facing women GPs are no different from those facing any woman in a man's world: achieving a balance between showing 'we're as good as the men' and changing the definition of 'good'. Although over 80 per cent of GPs are men, women GPs are apparently well accepted. Many group practices consider it useful to have a female partner, who often works on a part-time basis and may be excused on-call duty at nights and weekends. The emphasis in her job is often on women's and children's health: at one level this is a valid response to the demands of women for the choice to see a woman doctor, and it provides fulfilling work for a feminist.

On the other hand the 'lady doctor' is frequently a second-class citizen among the doctors in the practice: she may be exploited financially and her domestic commitments, even if they exist only as a future possibility in her partners' minds, may be used as an excuse to exclude her from decision-making amongst the partners. She also misses the opportunity to use the full range of her skills, and being on call, although burdensome, is also a very special part of general practice, seeing people in their own homes at times of crisis. Moving from a part-time to a full-time partnership, if another partner leaves or retires, may be the easiest route to a full-time partnership for a woman. Medicine, like the other professions, has a place for women – provided the women know their place.

When practices advertise for a full-time partner, what they generally want is not only a man, but a married man whose wife provides a devoted, unpaid back-up service. The doctor's wife answers the telephone, makes meals available at odd and variable times to fit in with the doctor's unpredictable timetable, and provides a lot of emotional support because the doctor is inevitably drained by caring for his patients. A full-time woman GP must make her own arrangements – and we have not even mentioned child care.

So pervasive is the male tradition in medicine that it is easy to forget that there are increasing numbers of women in medicine and that, although our training may teach us to act like men, most of us do identify with other women. Looking for sisterhood in our professional lives can be a way to rally the support of women doctors (including those who do not see themselves as feminists), for a different way of looking at medicine.



> I once went with two other feminist doctors to a local GP meeting about rape. Initially, the reaction to the male speaker was a great deal of sniggering and misogynist 'joking' from the male doctors present. When the three of us confronted them with this behaviour, it allowed the few other women present to voice their feelings and fears about rape – especially our vulnerability when visiting patients at night.

What is the best strategy for influencing other doctors? We often feel that we do not fit in at all in medical meetings, and it is easy to be marginalised as eccentrics if we express our ideas too freely. Camouflaging ourselves with conventional clothes and attitudes does not change anything and also puts us at risk of devaluing our feminist principles. One tactic for dealing with this is to keep a low profile until we have established our credibility, and then express our own ideas.

> It can be hard to maintain the low profile in the face of such comments as 'but women's position in society isn't a political matter'. My façade was shattered, before I had time to phrase a more diplomatic response, by my impulsive retort 'I've got news for you'. Some progress can be made, though: at the local GP training course, a speaker had said that women ask their GPs for more emotional support than men do, implying that women, being weaker than men, have a greater need for such support. I pointed out that women spend a lot of their time and energy giving emotional support to many people in their lives, and often have no-one but the GP to turn to for their own emotional support. A respected male colleague, sitting behind me, murmured, 'That's a good point'. I was surprised that it seemed to be a new idea to him, but pleased that he did, at least, accept the truth of it.

The need to maintain our credibility with the medical profession can come between us and the people who seek our help.

> At a recent home delivery, the birth was imminent when the baby's heart began to show signs of strain by beating more slowly. The midwife and I felt we might need to transfer her to the hospital for a forceps delivery. It is only a five-minute journey and I had few fears for the baby's well-being, but I felt very worried about my reputation with the local obstetric consultants, because I would have to admit that I had gone against accepted medical practice by agreeing to the woman's request that her first baby be born at home. (In fact, the 8lb baby girl was born, healthy and alert, at home before the ambulance arrived).

As isolated GPs, it is extremely difficult for us to influence the way in which our colleagues (even including our own partners) behave

to patients or other health workers, and teaching may be a potentially more rewarding area. Students and trainees can sit in on our consultations and have a chance to see the way we relate to the people who consult us, and judge for themselves the value of a 'feminist' way of working. This is much more likely to convince them than the angry interjections we find so hard to suppress at meetings.

### The women's health movement

Many feminists would say that it is pointless to try to influence individual doctors in an attempt to change the treatment of women by the medical profession as a whole. Certainly, it is pressure from the outside which has brought about most changes in medical practice – the recent trend away from routine high technology maternity care is an obvious example.

Knowing this, we have both been involved in various groups within the women's health movement. We came to them accustomed to praise and a warm feeling of self-satisfaction as doctors who worked in a more sisterly way than most. It came as a shock, therefore, to discover that feminists saw us as representatives of the very profession from which we felt so different. It was hard to face the uncomfortable truth that, in some ways, we inevitably act like arrogant and insensitive professionals. Our training not only accustoms us to taking a lead and being listened to, so that we intimidate less articulate women, but also gives our contributions the weight of professional opinions, when in reality they may be only personal experiences.

But it is a challenge to act as a resource for groups without using our status as experts to provide answers and control the outcome of discussions. Sharing information without passing on the assumptions and values which we absorbed with it means facing up to the disturbing fact that a lot of professional practice is based on myth and tradition with as little (or less) validity as the 'old wives' tales' which the medical profession disparages (see Chapter 6, Chamberlain (1981) and Ehrenreich & English (1979)).

We have learnt that feminism demands a new approach, not only to the way we practise, but also to the 'scientific facts' on which our knowledge is based. We have had to reassess critically whether there is any scientific basis to the medicine we practise, and the significance of science relative to individual experience (our own and other women's) and to our social and political



environment. In our eagerness to purge ourselves of our expert status, we should not go to the other extreme and insist that we have nothing of value to offer.

> I have been invited to speak at several meetings of different groups of women discussing the menopause. Everyone soon realises that the women in the room (often 20 or more) have between them an enormous fund of direct knowledge of the menopause, but maybe I can tell them a bit about what doctors say about it, and pass on experiences from women who have consulted me as patients.

Another way in which we can be useful is in giving practical support to feminist initiatives, such as setting up women's refuges and Rape Crisis Centres. Applications for funding and premises may be more credible if a doctor is on the management group. Once centres are in operation, we can act as informal advisers if we are asked by the women involved. We are interested, too, in the development of feminist Well Woman Centres. It is, however, increasingly clear that these need to be quite different from Well Woman Clinics which replicate conventional medical institutions, and it may be more appropriate for us to offer quiet support than to take a leading role. (This issue is discussed fully in Lisa Saffron's article (Saffron 1985).) We have also found that being part of campaigning groups like the National Abortion Campaign minimises the difficulties of our position. Professional status is irrelevant to much of the work such as duplicating leaflets or organising meetings and we can participate on an equal basis with less temptation to become 'experts with the answers' in discussion and planning.

Although we both became involved with the women's health movement because we felt that we had something to offer, we now know that our contribution has been much smaller than their contribution to our continuing education. Medical training has narrowed our vision: we need the broader vision of the women's movement.

### An alternative structure

We worked together for four years in a collective general practice in inner London, which was a conscious attempt to set up an alternative to conventionally organised practice. The experiment ended in 1984 (well after both of us had left) with a bitter dispute between one of the doctors and the rest of the workers at the

practice. This painful end of a very important part of our working lives has made it difficult for us to write this section; we have chosen to present a brief description of the practice and then concentrate on what we have learnt from the experience of working there.

The collective included a majority of women; not all of them described themselves as feminists, but feminist principles underpinned the relations between workers, patients and other people and institutions. There were several general workers who did reception duties, but who also developed relationships with patients which were explicitly recognised by us all as important, nourishing and healing. They suggested and initiated ways of dealing with patients' problems and also learned some basic medical skills like syringing ears and taking cervical smears – this helped to take some of the mystery out of the doctors' tasks. The collective also included acupuncturists, psychotherapists, and women who had learnt health care skills within the women's health movement, in addition to the doctors. We tailored the practice finances to pay all the workers at an equal hourly rate. All of us worked part-time.

We constructed a two-tier decision-making structure in the practice: all the workers met weekly to decide day-to-day matters, while broader issues were to be decided by a management group of workers and patients, which met monthly. However, the doctors who held the contract with the Family Practitioner Committee (see page 116) were legally responsible for everything which went on at the practice, and were, in reality, the employers of the rest of the group. Another important inequality among the workers was that we doctors (and other professionals such as the acupuncturist) could supplement our wages with highly-paid part-time work outside; we also gained prestige and approval from feminists and socialists for our commitment in working for a 'low' wage, while the receptionists took home only their wages and received no acclaim for their commitment.

What did we gain from our experience of working there? It was exciting to work in a setting for which we all took responsibility, and which we could change as our ideas and understanding developed. What we both valued most (and now miss) was the support and criticism of a group of people who shared broadly similar values and aims. We did not waste energy swimming against the professional tide, and could reclaim important parts of ourselves which our training had devalued and suppressed, for example humour and spontaneity. The democratic atmosphere allowed us to develop an open, informal approach to staff and patients, which we have been able to bring to our subsequent jobs. We also felt free to be honest with patients and other workers about the stresses affecting our behaviour on a particular day, such as feeling unwell, having a sick child at home, or running late, rather than having to try to appear infallible.



In the workers' group at its best, we were able to share our skills and experiences in a way which is impossible when everybody has a rôle and sticks to it. We learned a lot from working with alternative practitioners – we did not acquire any specific new skills, but their approach taught us to look at people's health problems with a broader perspective than that covered by our training as doctors.

We also learned to help patients gain more control in outside situations, by involving them in decisions about their own health care, and by providing as much information as possible. Even when medical information is made available to people, it may be in incomprehensible jargon, and we learned to fulfil a valuable role as interpreters of such medical mystification. This also applied to patients' records, which are usually kept secret from them. Legally, NHS records are the property of the Secretary of State for Social Services, and it is only convention which stops doctors showing them to patients. In the collective practice, anyone who wanted to could look at their own records, which are a collection of GPs notes, letters from hospitals and others, and results of medical tests. We soon learned that it was necessary to do this with someone nearby to provide explanation and support, as the material may be distressing or insulting – though it is sometimes just disappointingly inadequate. In our subsequent jobs, we have both continued to offer people the opportunity to look at their medical records.

The collective practice developed other important innovations – for example, both the antenatal clinic and the well baby clinic were held in a group setting, with the midwife, health visitors and doctor taking a less controlling role than usual. This allowed women to learn from each other's experience and support each other. The explicit politics of the collective also allowed it to create an atmosphere where women felt safe to reveal things which they might have been reluctant to expose in a conventional practice. Lesbians, for example, knew that their sexuality could be discussed, when relevant, without being focused on as pathological or problematic. Women who had been raped were able to come to us

knowing that we would offer sensitive and sympathetic help as well as medical advice and treatment. When women trusted us in these sensitive personal areas, we had to be careful to consult them about what they wanted us to reveal about them if we referred them elsewhere, although we could not ensure that they received equally sympathetic treatment from other agencies.

We do not wish to make a final overall judgement on the practice. Its history demonstrates that no-one can set up a feminist utopia in a single practice; at a time when the very existence of the NHS is under serious threat, we may be forced to use our limited energy to defend it, rather than to develop new structures. But we are proud to have worked in this radical project which for a few years acted as a focus of inspiration for people struggling to find a better way of doing things.

## Working within existing structures

Both of us now work in ordinary health centre practices – to what extent have we simply 'sold out' to the liberal general practice establishment? We have already mentioned that our experience in the collective practice helped us to develop a more personal approach to patients and fellow-workers, and that we learned to act as mediators between patients and 'the system', and as communicators of medical information. Working within the existing structure does not mean limiting ourselves to individual relationships with patients. We can, for example, be involved in setting up or supporting groups of women with shared problems, such as the successful menopause group at the health centre where one of us works. Unfortunately, this group also illustrates a major drawback of working within existing structures, namely that other people can limit worthwhile projects: the menopause group is hardly publicised within the building, because the other GPs worry that 'their' patients might receive medical advice which they disagree with.

Working in our health centres would be more fruitful if there were other feminists working with us; we get a lot of warm support from both patients and staff, but almost nothing in the way of constructive, sisterly criticism and feedback like that we received at the collective practice. And if there were other feminists at the health centre, we might be able to work together to challenge some of the established systems of which we feel critical.



In the context of working within the Establishment, perhaps we should seek representation in the influential decision-making organisations in the medical profession, such as the British Medical Association, General Medical Council and Local Medical Committees. Feminists should have a voice in these powerful bodies, and we greatly admire the few feminist doctors who are brave enough to sit on them and face the isolation, frustration, anger and boredom.

We feel it is important, especially in the present political climate, for feminist doctors to be involved in activities which defend the National Health Service. This is not the place for a detailed discussion of the issues involved in defending a system of which we are also very critical. Doctors' support is, however, much valued in campaigns against hospital closures and privatisation of ancillary services. We also need to find effective political ways of expressing our opposition to private medical practice. Patients sometimes ask us to refer them privately to specialists, and it is hard for us to refuse someone with whom we have a good relationship. A few doctors' refusals to refer individuals for private treatment will have little overall impact on the system. And in some areas, such as psychotherapy and abortion provision, we cannot avoid using private practice to supplement the inadequacies of the NHS (see Rakusen 1982).

The Medical Practitioners' Union, which attracts many left-wing doctors, is an organisation where feminists can have a voice and which gives us a base in the trades union movement, but unfortunately it has little real influence, especially under a Conservative government.

Women in Medicine is an organisation of women doctors, medical students and other interested women. It varies in strength in different parts of the country; in some areas its local groups provide a good forum for discussion and a structure for mutual support. It also holds national conferences, publishes a newsletter and stimulates research, for example on the employment and working conditions of women doctors (eg. Schofield & Ward 1985). Doctors for a Woman's Choice on Abortion provides medical influence and backing for the feminist campaigns on women's reproductive rights.

Even within the most conventional structure, general practice offers a unique opportunity to become involved in, influence and be influenced by the lives of a huge variety of women. As doctors

we have access to considerable resources, and it is a challenge to learn to use them in a principled, feminist way.

### Keeping ourselves sane

Whilst writing this, we have both been aware of how far what we do at work each day falls short of the ideals we have been describing. This is partly because general practice is, by anyone's standards, a stressful job. Although we do not spend our days, as is popularly imagined, making life-or-death decisions, there are other stresses: long, antisocial hours including not only nights and weekends on call, but split shifts with morning and evening surgeries, close contact with many distressed and vulnerable people in a short space of time, and a pressurised workload determined by unpredictable demand.

For feminists, and indeed for socialists, there is the additional stress of trying to work in a politically principled way within a health service and a society which does not share our principles. We are working 'in and against the State' (London–Edinburgh Weekend Return Group 1980). We juggle with our power and professionalism on the one hand and our sisterhood and humanity on the other, patch up the casualties of the system and send them back, we hope, fighting and strengthened. To continue functioning, we know we must set limits to the amount of work we take on and find space and support for ourselves. Or are we indeed 'superwomen' and not like other women we lecture (counsel?) about taking space and finding support for themselves?

On a practical level, we need to sort out our conditions of work in order to survive, and this really means our long, anti-social hours.

> We are well paid – I often wish I could swap money for time.

Nights and weekends on call can be exhausting and make us quite unfit to respond sensitively to anyone after a busy, sleepless night, as well as interfering with the rest of our lives.

> Last night, I spent the 2 hours between 3 and 5 am at the home of an elderly woman and her husband, who was dying of stomach cancer. The night nurses from the district nursing service were there too, and I felt a sense of satisfaction at the care the couple were receiving, and the way they were able to communicate honestly with each other. But when I came home I could not sleep, reflecting on the implications of her remark, 'You know, I think he wants me to go with him. We did everything together'. This morning I groped my way through surgery like a zombie.



Apart from our personal need for time off, which we owe both to ourselves and to those we are close to, we know that we work less well without it. This is not just because we are tired, but because it is easy to become immersed in being a doctor and lose all sense of anyone else's reality, if being a doctor is all that we do. We also get to feel that the long hours and heavy responsibilities justify our privileges, but self-sacrifice is not a political position, and altruism usually covers less admirable motives. For example, we are both susceptible to the thrill of becoming 'indispensable' to our patients, although as feminists we know that it is counter-productive and harmful to make people dependent on us.

We should not confuse dependence with the need for a continuing relationship with our patients. When people call on their GP, they want to see someone whom they know and who knows them. Lack of continuity of care is a major criticism of the NHS, and the recent attempt to limit the use of deputising doctors reflected widespread concern about this issue. Our need for time to ourselves has to be considered within this context.

GPs traditionally get a lot of support from their wives – in fact, the view of general practice we both received as medical students made it difficult to see how one could be a GP without one. Life as a GP is very much easier if we have friends, companions, lovers or spouses with whom we can share the stresses of the day.

Meetings with other GPs may be another way of finding support, but we both find we often feel like outsiders amongst them, and this may be as true amongst women doctors as men. Also, discussions among doctors are usually more competitive than co-operative, and we may come away feeling our confidence undermined rather than strengthened.

As feminists, we seek support in a group of women in similar situations, but should this be just doctors or a more general health workers' group? The workers' group at our collective practice, women's health groups and individual feminists concerned with health care have all provided us with enormous support, stimulation and criticism – but it seems to us that only a limited amount of their energy can be spared to support doctors.

Is it more appropriate, then, to look for support in a group of feminist GPs, if we are lucky enough to work in an area with more than two or three? If this is our only support group, we are likely to lose some of our radical perspective and even degenerate into self-justification and self-pity, forgetting that being at the top of a hierarchy warps one's view of the world. On the other hand, such

a group is a much easier setting to look at our feelings about the problems and contradictions we face as GPs.

> I have never forgotten the response of one of the two men at a practice collective workers' meeting, when I was talking about how trapped and uncomfortable I feel about my power as a doctor: He said 'You sound like a man talking about male power.' It is a useful, if painful comparison. We need support but we need to be kept on our toes – we have to be in contact with other feminists, health workers or not, as well as other feminist doctors.

Perhaps the basis of staying sane is to remain realistic in our expectations of ourselves. Providing a service to a huge range of people in our unequal and unfair society is bound to be a juggling act and we are not going to be able to change the world from our surgery chair, nor can we get it right every time. Often there is no right answer, and we cannot be perfect feminists at work, any more than in the rest of our lives – to expect that we could is not only unrealistic but will leave us disillusioned and exhausted.

As Mary Howell emphasises (Howell 1979), 'feminism is real only insofar as we can represent its perspective in the dailiness of our lives.' Our greatest satisfaction as GPs lies within our everyday relationships with individual patients: it is here that our feminism is both most useful and most problematic, as we will discuss in the next section.

## WORKING WITH PEOPLE WHO CONSULT US

Most of this section is about feelings and their social and political setting – not only because these are the areas in which feminism had made the greatest contribution, but because they are always central to any GP's work.

### Relationships with patients: some general problems

We would like to see our relationship with the women who consult us as that of 'skilled but sisterly helpers' (Leeson & Gray 1978) and we feel most comfortable if we can work in an egalitarian way. But it is very important to remember that, like it or not, we are in a position of authority over people who come to us for medical help. We have the genuine authority which comes from the skill and experience we have been lucky enough to acquire... and a great deal of false authority which comes from the inappropriate power we are given by society. Sometimes we can turn this to the patient's



advantage: 'I suggest you rest in bed for 48 hours to give your body a chance to get rid of this 'flu virus. I know that'll be hard, but tell your husband and sons that they've got to do the housework, and that's doctor's orders!' (The problem is that we do not have quite enough authority: she may be allowed to take to her bed, but the cleaning, washing and shopping will be there to do when she gets up.)

Our distaste for our position of authority may lead us to pretend it does not exist. Not only does this put relationships between us and the people who consult us on a dishonest footing, but it is also a way of belittling our own achievements and usefulness, as women so often do. Another danger is that if our own authority is not openly acknowledged, we end up expressing it indirectly, and much more dangerously, when under stress – we may become resentful about our long working hours or heavy responsibilities, or suddenly start throwing our weight around when challenged. This is quite an uncomfortable area because it conflicts with our view of ourselves as feminists, but we have noticed that increasing experience and confidence help us to feel easier about acknowledging and using our authority in our work.

Finding a working style which is 'sisterly' but does not deny our authority is linked with another source of difficulty for feminist doctors: coming to terms with public expectations of us. We need to evolve a style which we can adapt to all our patients – of whatever age, sex, race and class. We must each find an approach (including dress, language, etc.) which is comfortable for us and which reflects ourselves – but it must also be broadly acceptable to a wide variety of people, most of whom are not feminists. Of course, once they come to know and trust us, our language and appearance become less important, and fewer eyebrows are raised when we turn up in trousers.

It is easy to underestimate how much doctors' authority and patients' expectations colour both parties' view of what is happening between us:

> On several occasions I have spent some time in what I thought was 'non-directive counselling', enabling a patient to clarify her own needs and work out what course of action was best for her, but at our next meeting she has said 'Thank you for your advice, doctor, I went home and did exactly what you said'.

There is a third dimension to the problem of 'authority'. We must be aware that, as doctors, we are invested with the official

authority of the State: in fact, GPs are increasingly called upon to act as agents of the State. We do this each time we write a prescription or a sickness certificate, but we are the key to many other services and benefits such as 'Disabled Driver' badges, supplementary DHSS payments for special diets or extra heating, and re-housing on 'health grounds'. In many areas it is almost impossible for council tenants to be rehoused without a doctor's letter to say that they suffer from an illness which is caused or made worse by their present accommodation. The accommodation in question may be a damp, crumbling, noisy, vandalised slum which would be unsuitable for anyone, regardless of their state of health. But we cannot refuse to participate without penalising the people who seek our help. We can also be involved in forcible admissions to mental hospitals, in taking children from their parents and putting them into care, and in sending elderly people away to old people's homes. Whatever our personal beliefs, and whether we use it or not, we have the power to make those recommendations, which represent a real threat to people.

Women have no reason to trust us, except on the strength of whatever relationship we build between us; our inevitable race and class assumptions as white professional women, and our ageism which makes us insensitive to the needs and feelings of both the young and the elderly, may lead to further mistrust.

If our relationships with patients go wrong, it may be because of what we represent, because of who we are, or because we simply do not get on as individuals. If we do not understand this, we can be surprised and hurt when people seem not to trust us despite our warmly informal manner, our good intentions and our real concern for their well-being. An awareness of the real power relationship helps us to look critically at what we are doing, and to realise that we have to earn people's trust and respect, not expect them as a right. Our training did not prepare us to deal with any of these issues.

Being locked into our authority as doctors is linked with an attitude of professional detachment which can lead to arrogance and insensitivity to people's feelings. Reacting against this, we can try to minimise the barriers between ourselves and the people who come to us for medical help, and to build a relationship like a friendship. But in doing this we make ourselves vulnerable and risk taking on board all the deep distress we encounter every day. This can be exhausting. Building a useful and sisterly relationship involves finding a balance between these two extremes at a level



which suits our own style: a certain amount of self-revelation ('I'm sorry I'm not being very attentive this morning, I was up half the night') can be very helpful, both in reminding the patient that the doctor is human too, and in making the most of our energy to provide a good service. ('Perhaps you could make a double appointment at the end of the week: I'll be more helpful then'.)

## 'A woman's right to choose'

It is apt that 'a woman's right to choose' is probably the best-known feminist slogan, because choice is exactly what most women are deprived of – not only choice about abortion, but about every facet of our lives. Few women have economic independence and, without this, the majority have few choices, but powerlessness can also make it difficult to see those choices they do have. Pointing these out and encouraging women to use them for their own well-being and happiness is a major part of our work.

These choices may be on a practical level – for example, in the collective practice we were able to offer women the choice of various conventional and alternative treatments. Most of the time, though, we are encouraging women to look at choices which affect them much more intimately. This is not as straightforward as it may sound. We are critical when other doctors impose their world-view on people's lives – for example, labelling women who wish to continue paid work as uncaring mothers – but our feminist principles are also a world-view. Imposing this is not only doomed to failure, but would achieve nothing in terms of the woman's self-esteem and confidence – we would be using our power to determine what is right for the woman, rather than encouraging her to decide. The other extreme would be to support all women uncritically, no matter what choice they made, thereby denying our experience as women, feminists and doctors, as well as denying our power.

We are constantly trying to maintain a balance between inflexible dogmatism and uncritical support – a common example of this is deciding how we can help a woman who lives with a violent man and 'chooses' to remain. She carries a double burden of guilt – that she has somehow caused or even deserves the violence she suffers and also that she does not have the strength to leave. Her friends and family tell her, and she may even agree, that she is a fool to stay, but male violence to women is largely condoned in our

society, and we internalise the prevailing view that 'she must have deserved it'. Meanwhile the radio plays 'Stand by your man'. If she leaves she must not only break her emotional ties and perhaps face extreme violence, but also negotiate a hostile system in an attempt to find money and accommodation. Her choice can only be made from a very small range of options and if we ignore this, we may leave her paralysed by feelings of guilt; on the other hand, if we support her uncritically within the situation, we may allow her to tolerate it longer than she would otherwise have done.

Similar conflicts arise when adolescents come to us asking for contraception. We support their 'right to a self-determined sexuality' (one of the demands of the Women's Liberation Movement) but often their sexuality is largely dictated by outside forces – the media, the fear of being left out, pressure from boys, and so on. Sometimes we cannot bring ourselves to ask young women about their sexual enjoyment – at least two-thirds of them say 'well, he seems to like it'. Not only are they not enjoying sex, but they seem to have no expectation that they might. Of course, we are willing to provide contraception, but we also want to find a way of helping them find our what they want from sex and life. Yet the same forces that push young women into sexual relationships which they may not want also characterise adults as killjoys who want to stop young people having fun. We find our status as powerful adults makes it almost impossible to talk about these issues with young women without being seen as authoritarian, which prevents any two-way discussion. During the time that we were writing this, it became illegal for us to advise anyone under 16 about contraception without their parents' consent. We welcomed the House of Lords ruling which reversed this change in the law, which had begun to have disastrous effects on the well-being of young women and made it very much harder for us to develop helpful relationships with them.

Young women often see their mothers as authoritarian and restrictive, and we become involved in this too because, as the mother's GP, we may be asked for help and support with her fears about the situation. Usually her concern is chiefly with protecting her daughter from early motherhood and shotgun marriage – she may have experienced this herself and know how hard it can be. We cannot forget that we are family doctors working in a community, whatever our criticisms of the family or community as institutions may be. We need to support both the adolescent women and their mothers and try to reconcile the apparent and



real conflicts of interest, respecting medical confidentiality and our interlocking relationships. Similar and even more difficult situations may arise when we act as confidante and supporter to two or more women involved with the same man (who, in general, does not come to see us at all, of course).

A woman's right to choose may also mean a woman making a choice which we see as a bad one for her.

> I remember one woman in particular, whom I referred for an abortion. I knew her well, and was convinced that an abortion would be disastrous for her. In this case, as in others, I had misjudged the situation, but I find it difficult if it turns out that a woman's choice has disastrous consequences that I have foreseen. Ideally, I support her through her distress while helping her to understand what has happened without blaming herself. In practice, I often have to wrestle with my feelings of resentment at her 'stupidity', although I know these feelings are unfair.

Sometimes the greatest struggle is to allow a woman the choice not to discuss things with us. She may come to us for a service – referral to another agency, a sick note because she is too distressed to work – but she is handling the situation herself and does not want us to be involved. Our training as caring GPs urges us to probe deeper, but this may be an intrusion. If, for example, a woman has come to a firm decision that she needs an abortion, do we have a right to involve ourselves beyond ensuring that this is medically possible and is really what she wants?

Many choices we may wish to offer women involve us in extra work – home births are the major example of this. We need to be available 24 hours a day for a month – two weeks before and after the date on which the baby is due – and then be prepared to leave whatever we are doing once labour is under way. This can be very disruptive, not only of our own lives (one of the few days we had together working on this chapter was taken over by a home birth) but also of those of our other patients. Home deliveries, although stressful and demanding, can also be very rewarding and we develop very special relationships with women who request them. Similarly, it is easy to work closely and rewardingly with women who share our world-view. It is tempting to devote a lot of our time and energy to these women, but if we do, this is at the expense of women less like ourselves with whom we feel less empathy. This is much the same as the tendency of doctors in general to favour articulate middle-class patients.

## Don't blame the victim

The recognition that individual women can, and often wish to, take responsibility for their own lives, does not alter the fact that most of the factors causing disease are beyond our individual control: for example, poverty, poor housing and work conditions, unemployment, pollution. But a lot of today's preventive medicine and health education emphasise individuals' responsibility for their own ill-health, and blame the victims rather than the social pressures which make them unhealthy. Women, in particular, come in for a good deal of blame: not only for their own problems but those of their children, husbands and parents.

Smokers, people who over-eat, people who escape from their problems with tranquillisers or alcohol – all end up with an overwhelming feeling of personal guilt, which is useless as well as uncomfortable. Undermining people's self-esteem does not help them to change their unhealthy behaviour.

How can a feminist approach help us? Ideally, we need to strive to understand the pressures which bring about a woman's unhealthy behaviour, both in the particular circumstances of her own life and in our society in general, for example, the pervasive images of idealised women's bodies in advertising. Then perhaps we can share our analysis with the patient herself, and work out a plan of action together, so that she can take more control over her own health. This involves both of us understanding the many factors which make this difficult for her. In other words, the doctor becomes an ally helping the woman take control, rather than being yet another outside pressure on her.

These ideas are very hard to put into practice in a ten-minute appointment. Not all women will accept this approach, and we are often faced with the problem of how we relate to women who want treatment which as doctors we see as useless and harmful, and which as feminists we see as a damaging response to sexual stereotypes. Slimming pills are a particular bogey for both of us: they do not work in the long term, have unpleasant side-effects and may be addictive. They also hold out to women the hope of a magic, individual solution to what is essentially a political problem: the unreal images to which women are expected to conform. When a woman tells us that her marriage will break up if she does not lose weight, that this is her last chance, that she has tried every known diet, Weight Watchers and a compulsive eating group, that she understands the risks of slimming pills and still thinks it worth it... are we justified in using our authority to with-hold



them? Slimming pills are no more harmful than dozens of other widely-used drugs, for many of which there is no real proof of long-term effectiveness (eg. Valium). And the other side of this society's slimness fetish is the punitive attitude it (and its doctors) take towards obesity. Will she be able to differentiate our principled position from the punitive attitude of her previous doctor who belittled the problem, stressed will-power, implied that she was greedy or self-indulgent and totally failed to respond to her distress? How do we respond to her distress and avoid adding to her guilt and low self-esteem, without going along with her analysis and accepting her solution? We often fail.

> At one recent morning surgery, one woman left in tears and another vowed to change doctors, because I refused them slimming pills.

On the other hand, the occasional 'success' makes the feminist approach seem worthwhile. Women who over-eat often do so in response to needs other than hunger (Orbach 1978; 1982); frequently it is for comfort, or to suppress anger.

> Sometimes I ask a patient to write down not only everything she eats, but also what she feels at the time. The most striking example I can remember is 'I had a row with my daughter when she came home at midnight, and then ate a quart of icecream from the freezer.' Discussing what she has written, we can develop an understanding of what her eating habits mean for her, and then find a way of changing it... or sometimes the focus of the consultation shifts from the food to the feelings themselves and other ways of dealing with them.

Difficult issues of guilt, blame and responsibility also arise when women come in with family problems, either with children who, for example, do not sleep or refuse to go to school, or with marital problems. It is not unusual for a couple to come together to see us and present the woman as 'ill' because she is bad-tempered and resentful, or because she no longer responds sexually. Very often there is almost a collusion between the husband, who appears very caring and concerned, and the wife, to lay all the blame on her and deny that he has any responsibility. They wish to find a physical basis for the problem, preferably one which can be treated with pills. The recent publicity given to premenstrual tension is a very mixed blessing, as it can be used to explain away women's bursts of anger about real sources of dissatisfaction in their lives. Our response to these situations often involves a compromise. Our analysis stems from our commitment to women's well-being, informed by our own feminist perspective,

but we have to recognise that the couple do not share our world-view and may not be interested in making far-reaching, uncomfortable changes in their attitudes and lives.

## The sisterhood in women's lives

When women find a sympathetic woman doctor who is prepared to listen, they often unburden themselves, perhaps for the first time, of painful personal problems. It is very easy for these women to become dependent on the doctor. This is rather gratifying for us, but results in the woman having less control over her life. One important way of avoiding this is to encourage women to find sisterly support outside the surgery. This means asking them about friends, sisters, mothers, daughters in whom they might or do confide. This is an easy and accessible idea ('a trouble shared is a trouble halved') rather than a piece of high-flown psychotherapy. Some women may find it hard to expose themselves in this way, though, and sometimes the family may not be an appropriate place for a woman to seek support because of her existing role within it.

It is also possible to put women in touch with groups set up by women with particular shared difficulties and interests – for example, a menopause group which is part of the local women's health group and a mastectomy support group at our local hospital. Referrals to compulsive eating groups, Women's Aid, Rape Crisis Centres or other feminist agencies may also be useful. It can be very helpful to put individuals with a shared difficulty in touch with each other, although we must be scrupulous about seeking permission first. For example, one of us introduced two pregnant nineteen-year-olds, who each felt too shy to go to antenatal classes alone.

Nevertheless, sometimes the doctor really is the only person the woman feels able to confide in. We may be able to do nothing and have no useful advice to offer, but just being there as a listening ear is genuinely healing. It is a delicate and unequal relationship, and one problem is how much the doctor should say about herself and her own experiences. It is not hard for us to talk about our own experiences of having coils fitted, self-help remedies for cystitis or Maureen's children's love of junk food, but we are both more reticent about our personal relationships. We must remember that the time women spend with their GP may be the only space they get to themselves and we could easily crowd them out if we are too intrusive. Also, we have to remember that what a patient tells us is protected by medical confidentiality, but what we tell her is not. People enjoy discussing their doctors and in both the communities in which we work, gossip travels very fast.



Another pitfall is that the sharing of our experience as women with patients may make them feel that they are not as good at fulfilling a woman's role as we are.

> Many women know that I have two small children and some know that I do not live with their father. They often seem impressed that, in this situation, I also manage a demanding job, and see me as some kind of superwoman. I feel a fraud, because they do not know how disorganised my life really is, despite my many advantages compared with most single mothers. Although I am gratified by their admiration, the competitive atmosphere between us upsets me. Recently a woman who was half an hour late for a 10.15 appointment explained that this was because of the difficulty of getting out with two small children. I was relieved that I stopped myself (although only just) from saying 'I have two small children and I'm here by 9 o'clock'.

## Helping women to get what they need

Many women's lives are dominated by the constant outpouring of emotional and practical support in their role as carers. This is most obvious within a family, where women in their 50s may find themselves caring for elderly relatives and neighbours, a husband, children and grandchildren. It also happens in most situations shared by men and women – work, friendships, clubs. These demands may overlap and the woman may become pig-in-the-middle – a phrase many of them have used to us. Women act as emotional safety valves. They absorb the tensions and problems, and provide support for everyone. With no-one to do the same for them, they may develop physical and emotional manifestations of stress. This role is largely unrecognised and always devalued. It is taken for granted, often even by the woman herself, as a natural attribute of women.

> This was brought home to one woman when her husband had a heart attack. She not only supported him emotionally, spending hours at his bedside, but also took on all the practical and financial problems and continued her own job. She was simultaneously supporting her daughter through a marriage break-up. A few weeks later she took an accidental overdose of tranquillisers. Her husband, although he knew she had taken too many pills, left her in a deep sleep for 36 hours before calling a doctor. When she came to see me the

next week, she poured out her enormous anger and hurt that a man for whom she had so recently done so much could be so selfish and callous. She realised he had become self-centred over the years and particularly since his illness. She went home and confronted him – forcing him to recognise, and claiming for herself, her strength, energy and commitment.

Women may feel they have no right to ask for time and space for themselves, although lack of these is often the main problem underlying the symptoms which bring them to the doctor. They come instead on the pretext of some minor physical, and therefore respectable, complaint, or of seeking help for someone else – usually a child or husband. Even when the woman has found a space to express her distress, she may still feel guilty about it. As many as half of the women who have unburdened themselves to us say as they leave 'I'm sorry to have wasted your time' – not only feeling that their distress is unimportant, but also devaluing what has passed between us.

This feeling of having no right to her own space is not limited to the medical field. It often permeates a woman's whole life, making it generally bleak and unsatisfying as well as undermining her health. She lacks 'True Rest' – this term, which originates from the Pellin Centre, means some activity which restores a person's strength and sense of well-being. Examples of traditional ways in which men find True Rest are angling and football. Sometimes when we ask women how they would spend their time for themselves if they had any, they are unable to think of anything. Sometimes it is sitting and knitting – usually for other people!

I like to 'prescribe' True Rest on a prescription form – writing 'one hour's reading, three times a week', for example. As well as ensuring that my suggestion is not forgotten under the pressure of shopping, work, collecting the children, helping the neighbours, etc., the prescription often provides a useful talking point for the rest of the family and is an appropriate substitute for the expected tranquillisers.

The low self-esteem of women often comes up in consultations. We have learnt through feminism how women undervalue their real achievements of, for example, bringing up a family, because society in general undervalues them. We cannot help women to value themselves unless we value them. Women also often lack sources of feelings of accomplishment in their lives, and sometimes it is possible, even in a short consultation, to help a woman find more purpose for herself, as Maureen's GP did for her as a child.



Recently I talked to a woman who asked for help because she felt unenthusiastic about sex with her husband. I said 'Tell me a little about the rest of your life'. She described a sense of frustration and boredom with her life as a housewife and mother of two small children aged 2 and 4, with a part-time 'little' job. She did not feel overtired, was very fond of her husband and did not dislike housework, childcare, or her 'little' job – but she felt that she wanted more. We talked about possibilities and she decided to apply for a part-time secretarial course. Next time I saw her she had recovered her enthusiasm for life in general. I am not sure whether her sexual feelings had changed, but this no longer seemed to be a problem.

The most consciously authoritarian technique I (occasionally) use is to set 'homework' for patients, and sometimes the hardest task is to persuade them to do something to please themselves. A woman who easily found time to keep a conscientious weekly diary of her eating habits, mostly because she felt it would please me, took about ten weeks to buy a small bunch of flowers for herself.

## Working with male patients

Working with male patients can be difficult for a feminist, but can also provide unique opportunities for bringing some of the insights of feminism to men. As most men have a woman in their life from whom they get emotional support, we are less likely to see men complaining of emotional stress, although they often come with anxiety-related problems. When men do bring emotional problems, they often choose a woman doctor – presumably because they prefer a woman to fulfil the womanly role of listening ear. We also often already know the man from the account of a woman who is close to him before actually meeting him; this reverses the common situation of a woman being defined by her relationship to a man. These factors often mean we are in a position to put forward to men a more woman-centred way of looking at the world.

It is not easy to find a way to help a man who confesses to beating up his wife, an unemployed man who feels unmanly and resentful because his wife is the breadwinner, and cannot bring himself to do any housework while she is out at work, or a man who complains of sexual difficulties but insists on viewing these as a mechanical problem unrelated to feelings or relationships. We do not want to fall into the trap of being 'understanding' and not questioning their assumptions about male rights. On the other

hand, as with all the patients we find it hard to deal with, we have a responsibility to provide continuing medical care, and we can neither make every consultation into an ideological battle, nor choose not to relate to them. Some men might solve the problem by choosing to see a male doctor, but they do not all do so, so we have to find ways of meeting their challenge.

Sometimes there are rewarding encounters with men who are prepared to discuss their role and their feelings openly with us.

> Recently I saw a 44-year-old man who said 'I just don't feel right. Is it the male menopause?' He then told me that his children, aged 17 and 21, were becoming independent and would soon leave home. He respected their independence, but was sad to realise that he would soon lose his rewarding role as a father. We talked about other ways he could find purpose and satisfaction in the second half of his life.

Some men feel as burdened as women by the conventional expectations of their role.

> A 61-year-old man came to see me complaining of weight loss; after tests to exclude physical illnesses, and some discussion, it became clear that he was very depressed because he was made redundant last year. I was not surprised that he felt very anxious about his greatly reduced income, or that he found his days empty and unfulfilling; the main source of his depressed feelings, however, was guilt that he is unable to provide for his wife as he was brought up to do.

In such situations, seeing a doctor who questions society's assumptions about male and female roles may help a man to feel less guilty and inadequate, and to find strength and a broader perspective with which to face the real, painful problems of unemployment.

Unfortunately, we are often unable to avoid reinforcing sex roles, which tend to become more rigid under stress such as physical illness when it may not seem an appropriate time to challenge them. For example, when a man needs to modify his diet, it is usually necessary to discuss this with his wife if there is to be any chance of change. We are thus confirming her in the role of unpaid cook and dietician. But we can at least comment on what is happening, even if we cannot change it.

## CONCLUSION

We hope that this chapter has given some idea of what we mean by a feminist approach to general practice. It is a patchwork of the personal, the political and the pragmatic. The contradictions of our position lead to constant compromises: how much we compromise, and which compromises we choose to make, will vary at different stages in our own lives, as well as varying between individuals according to our differing experiences and personalities, and the places and situations we find ourselves in. We can use a feminist perspective to increase our understanding of women's health needs and of our own position; we can find ways of sharing skills and knowledge with other women; we can be involved in campaigning on women's health issues; we can attempt, if we are brave, to fight the sexism of the medical profession and the health care system; we can try to set up alternative feminist structures.



Above all, we can try to carry out our own daily work in a principled, feminist way. This includes just being a good doctor! Our emphasis on the psychological, social and political side of our work may have obscured the fact that we spend a lot of our time dealing with people who are ill. There is no point in endlessly analysing the contradictions of our position if we do not remember to treat people with respect, to be aware of their embarrassment and fear, to take care to explain what we are doing and give information about the drugs we prescribe, and to warm our hands and instruments before examining someone.

We are sometimes asked why we continue to practise orthodox medicine when we are critical about its content as well as about its hierarchical structure. The heart of the matter for us both is the opportunity it gives us to be involved with almost everyone in our community: 90 per cent of people visit their GP in a five-year period. In a way nothing could bring us closer to women's lives, and that is the true privilege which we value most.

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from 1977–1982; and, most important of all, the women who have consulted us as patients.

## Useful Addresses

*Doctors for a Woman's Choice on Abortion*: 101 Burbage Road, London SE 24
*Medical Practitioners' Union*: 79 Camden Road, London NW1 9ES
*Pellin Centre*: 43 Killyon Road, London SW8 2XS
*Pelling Training Courses*: 15 Killyon Road, London SW8 2XS
*Politics of Health Group*: c/o BSSRS, 9 Poland Street, London W1
*Women in Medicine*: 34 Hunter House Road, Sheffield 11
*Women's Health Information Centre*: 52 Featherstone Street, London EC 1

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