work, we do not train for it. So graduation marks a sudden translation from a protected world into real life, where stress is inevitable. Without training, this transition too often results in distress and depression for those who first encounter stress in the unfavourable circumstances of an unsupported house job and when difficult choices have to be made between, for example, home and work. These matters are especially a problem for women, even though they are as resilient, if not more so, than men. Combined with sexual discrimination, it is scarcely surprising that the going is tough for women.

The facts of stress and dissatisfaction have been available for some time. What is now needed is abandonment of the attitudes which say on the one side, "I went through it in my time; why shouldn't you" and on the other, "My seniors are hateful and inconsiderate and I must have shorter hours." We need to restore some dignity and excitement into the practice of our profession, particularly in its early and impressionable stages, and also to recognise explicitly that there are privileges and responsibilities at all levels.

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2—Stress in women doctors

Women should not have to overcome more barriers than men

We know by now that junior doctors are demoralised. The hours, the facilities, inadequate support, and uncertain career prospects combine to crush their morale,[1] and not surprisingly some get depressed. But why are women doctors more depressed than their male colleagues, as Firth-Cozens suggests (p 89)? Are women inherently more susceptible to depression; or should we look to the additional pressures that their social position imposes?

In *What Women Want* Professor Anthony Clare argues cogently for a social explanation.[2] Epidemiological comparisons between men and women, he says, are fraught with methodological difficulty. The results of studies that correct scrupulously for social differences—age, education, background, achievement, occupational and social environment, and career prospects—show no difference between the sexes in the prevalence of psychological ill health.[3,4] The point is that men and women are not normally socially comparable. Men occupy the powerful positions, while women are disproportionately represented in low status jobs.

Women doctors do not escape this generalisation. Despite the fact that women comprise an increasing percentage of medical school entrants (47% in 1989 and over 40% for the past 10 years) and are well represented among senior house officers and registrars they continue to be found on lower rungs of the career ladder than their male counterparts. Among consultants only 6% in general medicine and less than 1% in general surgery are women. There are few women in academic medicine, and even in general practice only one in five principals is a woman.[5]

According to Allen it is children that block career achievement.[6] Full time working women have on average 17 hours a week less leisure time than men,[7] and a recent study of British social attitudes showed that when both parents work full time the woman still takes on most of the child rearing and household tasks: 82% of men and women said that the woman was ultimately responsible for these.[8] Yet the NHS does little to help. In 1988 district health authorities provided workplace nurseries for only 1179 children under 5 (H Harman, unpublished data). These places are not eligible for government subsidy and, unlike those in the private sector, do not qualify for tax relief.

Nevertheless, women doctors are more likely than other professional women to continue working with family responsibilities,[9] but at what cost to career and personal life? To the aspiring female clinician this potential conflict is added to the exams, frequent moves, and hard work that affect men as well. Small wonder that women find themselves shepherded out of the main stream into supernumerary part time training posts or clinical assistantships.[10] Those who make it to the top do so against the odds. At every stage they will probably have had to make personal compromises to conform to a male model, confronting role conflicts that men do not face.

Firth-Cozens calls for more flexible working practices so that women (and men) can take time off without jeopardising their careers. But today's unforgiving political climate makes these seem unlikely. Women general practitioners have been the first to feel its bite. Under the new contract existing flexibility in workload to fit changing family demands will be lost, as women wishing to change their hours of availability will need agreement from their family practitioner committee.

Yet those who expect women to choose between family and career cannot ignore the falling number of school leavers and the desire of patients for more women doctors. Just as women's work in munition factories in the first world war helped promote women's suffrage, so now demographic pressures may force those with influence to act. British industry has realised, long after most of its European competitors, that decent childcare facilities keep valuable female employees at work, and the BMA is now committed to campaigning for better facilities within the NHS.

Women should not be judged by different rules. They have proved their intelligence, competence, and commitment. Those who have reached the top are justifiably proud of their success in "a man's world." But more should be done to remove the additional barriers to women in medicine—and to make it as easy, or as difficult, as it is for men.

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Editorial registrar, *BMJ*

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