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Women in academic psychiatry in the United Kingdom

Although there seems to be a shared impression that the proportion of women in academic psychiatry is substantially lower than in National Health Service (NHS) posts, we are not aware of any empirical data on this. In the USA, women physicians have been shown to be more likely to pursue an academic career than men (Nonnemaker, 2000), but the number who advance to Professor appears significantly lower than expected (Reiser *et al*, 1993; Nonnemaker, 2000). Women in academic psychiatry in Canada also appear less likely to advance to senior positions than their male colleagues (Penfold, 1987). A recent survey of 44 academic institutions in the UK, carried out by the National Centre for Social Research (Blake & La Valle, 2000), found that women occupied lower grade academic posts than their male counterparts and therefore were less eligible to apply for project research grants. Those that were eligible were as successful in gaining funding as their male colleagues.

We aimed to investigate the number of women in substantive academic psychiatry posts across the UK and to compare it with that of equivalent NHS posts. We also investigated the gender distribution within sub-specialities in academic psychiatry posts in London.

Method

We contacted all academic psychiatric institutions in London (University College and Royal Free Medical School, Queen Mary and Westfield College, the Institute of Psychiatry, King's College, Guy's and St Thomas' Hospitals, St George's Hospital Medical School and Imperial College) and gained information on the numbers and types of academic posts and the gender of the current post-holders. We also contacted the Royal College of Psychiatrists for the same data about registered members in the UK. In addition, we obtained data on the numbers and gender of consultant psychiatrists and specialist registrars from the Royal College's annual census of psychiatric staff (Royal College of Psychiatrists, 2001).

The numbers and percentages of men and women in substantive academic posts were examined and the gender distribution analysed. The χ^2 statistic, odds ratio (OR) and 95% confidence interval (CI) were calculated to compare the numbers of men and women in academic and NHS posts, and the number of male and female academic psychiatrists who had attained a professional chair. We obtained the dates of full registration of professors at London academic institutions of psychiatry from the General Medical Council website and compared the length of time from full registration to present day for male and female professors using the Student's *t*-test. In addition, we contacted the Medical Research Council and Wellcome Trust to ascertain the numbers of male and female trainee psychiatrists awarded training fellowships.

Results

Table 1 shows the number of men and women in academic and NHS posts in the UK. Overall, males were significantly more likely than females to have an academic post as compared to an NHS post. Men occupied 81% of academic posts and 63% of NHS posts (P=0.000, OR=2.4, 95% CI=1.8–3.2). Men were significantly more likely to occupy a professional position than women (135/265*v.* 15/64, P=0.000, OR=3.4, 95% CI=1.7–6.7). Eighty-nine per cent of professional positions were occupied by men. Between 1993 and 1998, the Wellcome Trust awarded 29 mental health training fellowships, 14 of these (48%) to women. Between 2000 and 2002, the MRC awarded 14 training fellowships in health service research and neuropsychiatry to trainee psychiatrists, 6 of these (43%) to women.

Table 1. Gender distribution of academic and National Health Service (NHS) posts in the UK (Royal College of Psychiatrists, 2001)

	Male (%)	Female (%)
Academic		
Professor	135 (89)	17 (11)
Reader	5 (71)	2 (29)
Senior lecturer	120 (75)	39 (25)
Lecturer	5 (38)	8 (62)
Total	265 (80)	66 (20)
NHS		
Consultant	2203 (67)	1099 (33)
Specialist registrar	480 (51)	467 (49)
Total	2683 (63)	1566 (37)

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Table 2 shows the gender and grade distribution within psychiatric sub-specialities for academics in London. Men are overrepresented when compared with women in all specialities except learning disability and liaison psychiatry, where numbers were very small. Overall, the male:female ratio in London was 3:1 compared with 4:1 for the UK as a whole. General Medical Council registration data were obtained for all 11 female professors at London academic institutions of psychiatry and 43 of the 49 male professors. There was no statistically significant difference in the mean years since full registration for male and female professors: 29 s.d.=8.0 *v.* 25 s.d.=5.6; t=1.7; 95% CI of the difference in proportion was −0.77 to 7.9.

Discussion

The main findings from this survey were that, in psychiatry, women appeared significantly less likely than men to pursue an academic career and within academic posts, women were much less likely to occupy a professional position than men.

The main limitation of our survey was the possible missing data. We relied upon figures given to us by employees and personnel departments of the institutions included. These figures were, to the best of our knowledge, complete. The Royal College of Psychiatrists' data rely on members notifying the College of changes in post and relates only to subscribing members. The inaccuracy in this data was illustrated by the discrepancy in the numbers of lecturers, with the number in our London survey being greater than that reported in the Royal College's census for the whole of the UK. However, there is no reason to believe that any missing data would have introduced any systematic bias affecting our results. We included data on Wellcome Trust and Medical Research Council fellows because we felt that they were likely to pursue an academic career, but honorary specialist registrars employed as part of research grants were not included owing to the difficulty in obtaining accurate information about these posts, many of which are short term, and because we felt that they were less likely to lead to an academic career.

The very large gender difference at professional level could reflect the small number of women entering medicine in previous generations, especially when quotas for female medical students were fixed. However, comparison between mean time since full registration for men and women suggests that this may not be so, because female professors have been qualified almost as long as their male peers. Comparing the ratio of men to women among readers and senior lecturers (3:1) with NHS consultants (2:1) also suggests that the under-representation of women in academic psychiatry cannot be explained simply as a cohort effect. At the most junior level, numbers surveyed are small and evidence is mixed as to whether we can expect women to catch up in academic psychiatry. Data from the Medical Research Council and Wellcome Trust fellowship schemes are encouraging, but those regarding lecturers are less so,

Table 2. Gender and academic rank distribution within the psychiatric sub-specialities in London

	Social and community	General adult	Old age	Forensic	Biological	Child	Learning disability	Liaison	Eating disorder	Genetics	Substance misuse	Psychotherapy	Total	Male, m (%)	Female, f (%)
Professor	10m 1f	5m	5m 1f	4m 1f	11m 2f	6m 2f	2m 1f	1m 1f	1m 1f	2m 1f	1m	1m	60	49 (82)	11 (18)
Reader	2m	2m	2m 1f		2f	1m		1f	1m			1m	13	9 (69)	4 (31)
Senior lecturer	9m 2f	7m 6f	7m 2f	2m 3f	9m 1f	7m 1f	1m 3f	1m 1f	1m 1f	2m	2m		68	48 (70)	20 (30)
Lecturer	5m 1f	2m 2f	3m 1f	3m 2f	1m	1m	1m 1f	1f					24	16 (67)	8 (33)
Total	26m 4f	16m 8f	17m 5f	9m 6f	21m 5f	15m 3f	4m 5f	2m 4f	3m 2f	4m 1f	3m	2m	165	122 (74)	43 (26)

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such that future trends cannot be predicted at present with confidence.

Recruitment within psychiatry is currently problematic, and our findings highlight that we are not attracting and retaining women into senior academic posts. Over the past 2 years, a group of London-based female academic psychiatrists has met informally. Discussion among this group and at a workshop held at the 2001 Royal College Annual Meeting about the issue of gender disparity in academic psychiatry suggested a number of possible explanations:

(a) A perception that it is 'too hard' to combine academic, clinical and family commitments, illustrated by the lack of female role models in academic psychiatry, is supported by Blake & La Valle's (2000) findings that women scientists were less likely to be in a relationship than their male counterparts and less likely to have dependent children. However, female academics who did have domestic commitments were more likely to be responsible for household duties and childcare than male academics with children. Only 50% of women academics with children had applied for grants, compared with 62% of male academics with children. The survey also found that older universities (including all the academic institutions of psychiatry in London) were less likely than newer institutions to provide support in terms of career breaks and parental leave for academics with families. The discussion groups noted that there are very few part-time clinical academic psychiatrists, male or female, and felt that the difficulties of fulfilling both academic and clinical commitments within a part-time working week would be great. Acknowledgement of this and greater flexibility within working hours and the structure of academic careers are needed.

(b) Changing from NHS to academic employment or working on short-term research grants or fellowships can be daunting for women planning to have children because the arrangements for paid maternity leave may be unclear. Research grants are usually awarded over a fixed time period, with no provision for maternity leave, and arranging cover for carrying out or supervising projects can be problematic. Although women are legally entitled to maternity leave and Blake & La Valle's survey (2000) has led the Wellcome Trust and the Medical Research Council to address this problem, the discussion groups felt that the lack of clarity around this issue was a strong disincentive to women considering academic careers.

(c) A further issue was gender discrimination. This has been shown to occur early on in the careers of women in medicine. A study of 1000 medical students in the USA showed that 29% of women had experienced gender discrimination during their training (Mangus *et al*, 1998), and female medical students in Leicester reported gender discrimination, particularly in surgery (Field & Lennox, 1996). Gender discrimination has also been reported among female clinicians and academics working in radiology (Deitch *et al*, 1998), plastic surgery (Capek *et al*, 1997) and cardiology (Limacher *et al*, 1998). A large study of medical academics across the USA showed that women were more than twice as likely to perceive gender discrimination in the academic environment than their male colleagues and, although their academic productivity was similar, they had poorer career satisfaction (Carr *et al*, 2000). Although there have been no surveys of gender discrimination in psychiatry, there is no reason to assume that our speciality is free from it.

(d) Our discussions highlighted the issue of mentoring, which has been emphasised as an important factor in encouraging an academic career choice (Stewart, 2002). It was felt that female mentors would encourage female trainees to consider academic psychiatry and that more formal mentoring schemes would give all trainees the opportunity to make links with senior academics, regardless of gender.

In order to assess the issues raised in this paper and their relevance to academic psychiatry in the UK, further investigation is required. This could include a survey of academics' perceptions of the obstacles they have faced during their careers, including gender discrimination, the reasons for their career choice and trainees' perceptions of academic careers, as well as an exploration of strategies that might encourage talented junior psychiatrists of both genders to enter academic psychiatry.

Limitations

(a) Missing data: we relied on employees and personnel departments of the academic institutions to provide us with our data and did not include honorary specialist registrars in our survey.

(b) Any inaccuracy in the national figures gained from the Royal College of Psychiatrists' census (2001).

References

BLAKE, M. & LA VALLE, I. (2000) *Who Applies for Research Funding?* London: National Centre for Social Research.

CAPEK, L., EDWARDS, D. E. & MACKINNON, S. E. (1997) Plastic surgeons: a gender comparison. *Plastic Reconstructive Surgery*, **99**, 289–299.

CARR, P. L., ASH, A. S., FRIEDMAN, R. H., *et al* (2000) Faculty perceptions of gender discrimination and sexual harassment in academic medicine. *Annals of Internal Medicine*, **132**, 889–986.

DEITCH, C. H., SUNSHINE, J. H., CHAN, W. C., *et al* (1998) Women in radiology: data from a 1995 national survey. *American Journal of Radiology*, **170**, 263–270.

FIELD, D. & LENNOX, A. (1996) Gender in medicine: the views of first and fifth year medical students. *Medical Education*, **30**, 246–252.

LIMACHER, M. C., ZAHER, C. A., WALSH, M. N., *et al* (1998) The ACC professional life survey: career decisions of women and men in cardiology. A report of the Committee on Women in Cardiology. *Journal of the American College of Cardiology*, **32**, 827–835.

MANGUS, R. S., HAWKINS, C. E. & MILLER, M. J. (1998) Prevalence of harassment and discrimination among 1996 medical school graduates: a survey of eight US schools. *Journal of the American Medical Assocation*, **280**, 851–853.

NONNEMAKER, L. (2000) Women physicians in academic medicine: new insights from cohort studies. *New England Journal of Medicine*, **342**, 399–405.

PENFOLD, S. (1987) Women in academic psychiatry in Canada. *Canadian Journal of Psychiatry*, **32**, 660–665.

REISER, L. W., SLEDGE, W. H., FENTON, W., *et al* (1993) Beginning careers in academic psychiatry for women – 'Bermuda Triangle?'. *American Journal of Psychiatry*, **150**, 1392–1397.

https://doi.org/10.1192/pb.27.9.323 Published online by Cambridge University Press

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ROYAL COLLEGE OF PSYCHIATRISTS (2001) *Annual Census of Psychiatry Staffing*. London: Royal College of Psychiatrists.

STEWART, P. (2002) Academic medicine: a faltering engine. *BMJ*, **324**, 437–438.

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The future role of general adult psychiatrists

Peter Kennedy and Hugh Griffiths (2001) have convened a timely debate on the role and responsibilities of consultants in general adult psychiatry. They provide an analysis of difficulties in fulfilling this role, including inappropriate general practitioner (GP) referrals, excessive caseloads and increasing stress leading to premature retirement. They provide the jobbing consultants with two models of out-patient practice, both relative to the community mental health team (CMHT). However, they have not considered the potential effect of change currently underway as summarised below.

- The arrival of Primary CareTrusts who (directly or indirectly) will purchase consultant time and will influence new consultant job plans.
- The new consultant contract that has an element of performance-related pay, which will be influenced by the employer (most likely a Primary CareTrust).
- The emphasis on competencies for each sub-speciality (including general adult psychiatry) by the Royal College of Psychiatrists as part of specialist registrar training.
- An expansion of medical schools with an expectation that consultants will teach more students in the community.
- The imminent arrival of the new Mental Health Act with emphasis on rapid delivery of care plans, risk/benefit assessments and capacity judgements.

Kennedy & Griffiths do not describe views of GPs on the role of consultant adult psychiatrists. GPs deal with over 60% of mental illness in the community, which comprises 25% of routine general practice as described by Craig & Boardman (1998). They refer only a small proportion (around 10%) to secondary psychiatric services, with around 80% of referrals to secondary services originating from GPs. Severe mental illness accounts for a very small percentage of GP workload. The main problems are chronic depression with associated employment difficulties, marital dysfunction and substance misuse issues.

GPs refer on a pragmatic basis, usually considering issues of treatability and risk. Cases of somatisation and mental illness associated with physical disease are usually treated within the confines of primary care. General adult psychiatrists have not taken much interest in this area, although GPs have significant difficulties in dealing with these two groups of patients. In addition, the recent guidance from the National Institute for Clinical Excellence (2002) has advised caution when prescribing conventional antipsychotic drugs in the context of side-effects. These prescribing issues could potentially increase referrals of patients currently stable on conventional antipsychotics.

Many GPs accept the CMHT as being a single point of access to secondary services, as this often delivers a rapid assessment. There is, however, concern about a lack of transparency on competences and supervision arrangements for individual CMHT staff. In general, GPs acknowledge that the consultant has the expertise on prognosis and benefits from particular treatments, which are issues that both patients and carers seek information on – hence the need for a consultant opinion early in the referral process. Accordingly, the consultant also acts as a gatekeeper to CMHT activity.

GPs remain somewhat confused about the role of additional teams in the community, which include crisis resolution, assertive outreach, early intervention, forensic and substance misuse teams, alongside the generic CMHT. Both GPs and consultant adult psychiatrists are wary of 'cherry-picking' by these other services, leaving complex and risky clients to be managed between themselves, particularly when admission is imminent. There is also the additional problem of boundary disputes between general adult, old age and learning disability services.

Alternative options for consultants in adult psychiatry

Liaison–consultation model

This has been used within general hospitals to concentrate on adults of working age similar to those seen in primary care. A liaison service usually commences with a medically-staffed consultation service, progressing to a predominantly nurse-led service, with senior medical staff concentrating on liaison activity involving a combination of joint working and teaching. The liaison psychiatrist has special interests that generate a job plan with specific clinics. Examples of these include epilepsy, diabetes and chronic fatigue clinics.

If an adult psychiatrist wishes to work in primary care using the liaison model, they would have to move entirely into general practice with all consultations and clinics held in primary care and community hospital wards. Non-medical staff would subsequently join, with specific skills in psychosocial intervention involving compliance therapy, problem solving therapy, substance misuse management and cognitive–behavioural therapy. The consultant would jointly undertake management of specific conditions (with specific clinics), for example in

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