

## Women In Health Law

### WOMEN IN HEALTH LAW

#### Women in Specialist Training and Specialist Practice [1]

In 1983, R.P. Meagher QC, as His Honour then was, when President of the New South Wales Bar Association said: "Law is the study of those Statutes, and of the Common Law (as revealed in the precedents established by decided cases), which govern our increasingly complex multifarious activities".[2]

At the same time His Honour made what became a very controversial observation that there were multitudes of "academic homunculi" scribbling and prattling relentlessly about such "non subjects as criminology, bail, poverty, consumerism, computers and racism".

I suppose you might think it was a good thing that the nomenclature of the now accepted conglomerate "Health Law" had not been adopted when His Honour took legal academia to task for having the affrontery to be moving into modernity.

However one of the important points of His Honour's speech was the endorsement of the pupillage system of the NSW Bar. His Honour observed that "one can learn more in ten minutes from a skilled advocate than in a year" of theory. I will return to this important matter a little later.

In 1992 Justice Michael Kirby observed[3] that we had come a long way since 1901 when in a Scottish case [4] the Judge observed that an action between a patient and "a medical man" for damages was a case of a "particularly unusual character".

The reference by the Scottish Judge to the medical man is not surprising when one is reminded of the then current work "Law and Medical Men"[5] which noted the recent statutory recognition in England of a woman's right to become a registered medical practitioner and observed:

But now woman is no longer regarded as too good or too stupid to study medicine in America; in nearly every State in the Union she has free access to Medical Colleges [6]

Justice Kirby identified issues relevant to Health Law as not only those dealing with "malpractice", to use an American term, but also issues pertinent to genetics, health insurance and pharmaceutical and drug regulation, reproduction, resource allocation and tissue transplantation. These days this has been extended to in vitro fertilisation, the freezing of embryos and the human genome project.

A right to health is enunciated in the Universal Declaration of Human Rights[7] and the International Covenant on Economic, Social and Cultural Rights.[8] It is also found in the preamble to the Constitution of the World Health Organisation and in the Convention on the Elimination of all Forms of Racial Discrimination.[9] It is relevantly found in the Covenant on the Elimination of all Forms of Discrimination Against Women.[10]

Health Law has been described as having a universality of application, complex rules and an ever present need for sensitive decisions which take into account the high ethical content of this area of the law's operation.[11]

As in nearly every other facet of the law, the development of Health Law depends in the main on the facts of particular cases. Whether one is dealing with cases relating to organ transplants, euthanasia, or alleged momentary lapses of professional skill or judgment by medical practitioners, the development of the law will necessarily emerge from the issues that arise for judicial decision.

The medical practitioners or health care professionals who have been involved in the decision about whether, for instance, a patient is given resuscitation or are alleged to have been involved in a momentary lapse of judgment are essential participants in the development of Health Law. The Court must have regard to the conduct of those practitioners in each case.

There are other essential participants in the development of Health Law. In addition to the medical and health professionals they include the patient population, the legal profession, medical and other defence insurers, government departments and instrumentalities, public and private hospitals, the legislature and the judiciary.

The breadth of the topic that enticed me here this evening, "Women in Health Law", could venture into the study of the demographics of each of those groups. This would no doubt be a challenging and rewarding task but I thought it more appropriate to focus on a smaller but an essentially important issue that seems to me to have an impact on all the groups to which I have referred.

That focus is on the capacity of female medical graduates to obtain specialist training.

Specialists are obviously so important to the patient population. Apart from this pivotal role in the medical community, specialists also perform the very important task of providing the judiciary with expert evidence which helps shape judge made law.

It has been said that when female medical graduates enter medical academia they do much of what is known as the "political housework"[12] to achieve equitable conditions for women. In both the United States of America and Australia, findings show that despite equal productivity it takes women in medical academia up to twice as long to take promotional moves. The placement of female medical graduates in "leadership" positions is not keeping pace with the availability of talented women in the field.[13]

Recent studies have concluded that female practitioners who combine career and marriage and child bearing suffer what is known as considerable "role strain".[14] It is one of the paradoxes of the medical profession that whilst it advocates the importance of early childhood and infant development, when practitioners undertake to work part-time in order to spend time with their own infants they are effectively stigmatised for taking time off from training or practice.

It has been said that the negative value which is attached to this experience is strangely at odds with the profession's putative values. Even if trainees do find part-time employment they continue to face considerable problems and will work part-time and undertake training in their own time, thus effectively working almost full time on part-time pay.[15]

Such observations and findings have precipitated calls for an examination of the context in which female medical professionals are training and working. I understand that in 1993 the New South Wales Branch of the Australian Medical Association established a data base in the hope of attracting practitioners willing to share a training position. In support of this proposed scheme the Health Department made shared training positions available in a number of public hospitals.

There were "almost no takers" for this opportunity. It was said to be ahead of its time.[16] However by 1996 part time training was said to be a "reality"[17] because "a few women" were sharing training positions.[18] However it seems to me that the reality in this area is far more complex.

Although the numbers of women entering undergraduate medical school has risen markedly since 1974, such increase has not translated into a relative increase in the number of specialists, particularly in surgery. Approximately 50% of Australasian medical graduates are female however only 4%[19] of all surgeons and 18% of all surgical trainees are female.

Why is it so? There is no simple answer. The reasons are multiple and complex. [20]

The Federal Government has looked into the matter in some depth. The Australian Health Ministers Advisory Council established the Australian Medical Workforce Advisory Committee (AMWAC) which held its first meeting in April 1995. Part of AMWAC's 1996-1997 work plan was to prepare a report on Female Participation in the Australian Medical Work Force.

In its September 1996 interim report AMWAC noted that women then comprised 26% of medical practitioners in Australia. It predicted that by the year 2000 women would comprise 30% of the medical work force and 42% by 2025.

The Report concluded that female medical practitioners' work practices differed from their male counterparts in that they were more likely to be working part-time, working in a capital city or major urban centre, and working as a general practitioner.[21]

The report also concluded that women also tend to leave the practice of medicine or practise at quite low activity levels for a period of time during their career.

AMWAC reported that in Australia there was a comparative absence of female practitioners and female trainees in the majority of specialities and highlighted the need to ensure that there are satisfactory arrangements for women to leave the work force for a period of time and resume their careers at a later date with retraining opportunities to enhance skills and access to child care.

The report recognised the reality of the situation for female practitioners and concluded:

Full justice for women requires that they have an equal opportunity for professional success after acceptance to medical school. Women should be able to achieve more equitable representation and greater visibility across the medical profession.[22] Current demographic projections predict that if professional development and participation by women are not achieved, the work force as a whole will not fulfil the needs of a well resourced health service.

I venture to suggest that AMWAC's reference to a "well resourced health service" was not merely to dollars, but essentially to the demographics of the groups within the medical workforce, with a recognition of the need for a more gender balanced specialist group.

However, AMWAC did not have information on why particular career choices and workforce participation decisions were

being made. It therefore decided to conduct some follow up research in 1998.[23]

That follow up research provided AMWAC with material upon which it reasonably concluded that unless "those areas of practice with comparatively smaller numbers of female practitioners and trainees work at ways to offer more flexible training and work environments" the "gender imbalance between general practice and specialist practice and within the specialist disciplines can be expected to continue and possibly even increase".[24]

The report left no doubt in the mind of the reasonable reader that the problem was serious and warned "the issue will need to be dealt with". There is also no doubt that the focus was upon the speciality of surgery, and to a lesser extent ophthalmology, occupational medicine and radiology.[25]

It seems to me that the problems some female graduates face in securing training posts are caused in part by the perception that women will not work as long as men, they will take time off to have a family and they will need retraining when they return to the work force. This may present as a more expensive alternative than training a male graduate.

The resource allocators and those who decide on training post placements may still have the mindset that it is far more appropriate to "allocate resources" to trainees who will not need to take time off to have a baby, will not need to take time off to nurture the family and will not need retraining.

This is a mindset that will become more and more difficult to change as the controversy about the underfunding of the health system continues to grow.[26] But there has to be some innovative and independent thinking on this matter by the leaders in the medical community and the government.

You may find it difficult to disagree with AMWAC's conclusion that most of the impetus of workable solutions to create better access for female graduates to non general practice training schemes will have to come from the specialist Colleges, as the overseers of training, and the public hospital system, as the main provider of training placements and therefore the training environment.[27]

Although AMWAC claimed it was "quite possible that potential solutions will not be without some financial cost" I suggest that it is obviously probable that there will be a financial cost.

This is the cold reality and until there is a commitment to fund the move to a more gender balanced speciality group it will not happen. One can flirt with recommendations for workshops and suggestions of "possible" increases in cost, but it must be recognised that if the system is to be "well resourced" it must change. That will require the appointment of women to training posts notwithstanding the need for flexible working arrangements to accommodate the nurturing of a family. It will also require part-time training to be destigmatised by proper funding and total acceptance and positive promotion as opposed to an apparent begrudging tolerance.

This means a change in thinking and a change in culture. It will need the commitment of all the colleges and the public hospital system.

There is a glimmer of hope. The Royal Australasian College of Surgeons (the College) has taken steps that may just be the catalyst for the advent of a change in thinking and culture.

In 1999, in recognition of the need for a broad strategy to attract the best medical graduates to surgical training, the College instigated a pilot study of a facilitated personal mentoring scheme for basic surgical trainees.

This step may not be seen to be bold enough in the light of the obvious imbalance and clear evidence that some female specialists have experienced difficulties in negotiating more flexible working hours with public hospital administrators causing them to depart to the private sector.[28]

Mentoring systems have proved to be extremely successful in nurturing professional lives and careers. The New South Wales Bar has for many years utilised such a system but has referred to it differently. This relationship was known in the past as Master and Reader but is now known as Tutor and Pupil in recognition of the need for gender neutral language. This is the system Meagher JA was endorsing in 1983 as the best way of training and nurturing the new advocate. Today the NSW Bar Association's New Barrister's Course has at its core the tutor/pupil (or mentoring) system.

It is clear that the College has grasped the nettle and is willing to put in place a similar type of system to try to enhance the professional opportunities for female medical graduates to obtain surgical training posts. The stated aim is to work towards ensuring "some continuity of support and sense of cohesiveness for trainees".

Although such a system was informally in place previously, it may well have had the problems the NSW Bar faced in its previously very masculine and male club environment. However the Bar is gradually changing with the gentle coaxing of its fair minded leaders. A very important aspect of that change has been the willingness of female legal practitioners to join its very competitive ranks.

This is what appears to be needed in the medical profession with the firm leadership from the specialist colleges and public hospitals. Although the recent pilot study is but one step, in my view, it should be applauded and supported. It is hoped the impetus for change will be quite infectious.

The challenge for the medical profession and the government is "to adjust to the reality of womens' lives instead of denying it".[29] The aim is to enhance the opportunities for the numbers of obviously very talented female medical graduates so that they can achieve their full potential in the field of their choice.[30] This will have a positive impact on the community generally by the creation of a "properly resourced" health system.

If this aim is achieved, the prognosis for the future development of Health Law with a greater participation of female specialists will be greatly enhanced.

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- 1 Speech delivered by Justice P.A.Bergin on 4 May 2000 at the Series arranged by the New South Wales Women Lawyers Association at the offices of and in conjunction with Tress Cocks & Maddox.
- 2 The Scope and Limitations of Legal Practice Courses: Should they Replace Articles and Pupilage? 7th Commonwealth Law Conference, Hong Kong, 18-23 September, 1983.
- 3 Kirby J, "Introduction to Australian Health Law Bulletin", 1 *Australian Health Law Bulletin*, No. 1 September 1992.
- 4 *Farquhar v Murray* [1901] 3F 858.
- 5 *The Law and Medical Men*, R.Vashon Rogers, Jr., of Osgoode Hall, Barrister-at-Law.
- 6 *The Law and Medical Men* at p14.
- 7 Article 25(1).
- 8 Articles 10(3) and 12.
- 9 Article 5(e)(iv).
- 10 Article 11(1)(f).
- 11 Kirby J, "Introduction to the Australian Health Law Bulletin" , 1 *Australian Health Law Bulletin* No. 1 (September 1992).
- 12 Carroll & Quadrio, "Women in Australian and New Zealand Psychiatry: The Fat Lady Sings", (1991) 25 *Australian and New Zealand Journal of Psychiatry* 95 at 98.
- 13 Vicki L. Seltzer MD, "Changes and Challenges for Women in Academic Obstetrics and Gynaecology", *American Journal of Obstetrics & Gynaecology* (April 1999) at p 837.
- 14 Carroll and Quadrio at 98.
- 15 Carroll and Quadrio at 99.
- 16 Dr. Peter Arnold, "Why Women Should Specialise", *Australian Medicine* ( 4 March, 1996) at 16.
- 17 Dr Arnold at p16.
- 18 Most specialist Colleges now provide for part-time training within their rules. However there seems to be a need for some review of the rules with a view to amending them to positively embrace the system.
- 19 AMWAC's 1998 Report (see note 23) notes that the Australian figure is 1.4%. The 4% figure is contained in the RACS 1999 document "Pilot Study of a Facilitated Personal Mentoring Scheme".
- 20 The experience is the same in New Zealand. See P.J.Poole, "Room for More Women in Clinical Specialities", *New Zealand Medical Journal* (24 March, 2000) at 105.
- 21 P.J.Poole at p106.
- 22 Although it is over 100 years since the first publication of *The Law and Medical Men* these sentiments seem sadly contiguous with the sentiments expressed in that work.
- 23 Influences on Participation in the Australian Medical Workforce. 1998.
- 24 AMWAC 1998 at page 9 of the Executive Summary.
- 25 AMWAC 1998 at page 3 of the Executive Summary.
- 26 The President of the NSW Branch of the AMA was recently reported as claiming that the amount by which the system is underfunded is in the billions. See *Telegraph* 30/4/2000
- 27 AMWAC 1998 at page 10 of the Executive Summary.
- 28 AMWAC 1998 at page 6 of the Executive Summary.
- 29 M Angell , "Women in Medicine Beyond Prejudice", (1981) 304 *New England Journal of Medicine*, 1161-1163.
- 30 Phillipa J Poole, "Room for More Women in Clinical Specialities", *New Zealand Medical Journal*, (24 March, 2000) 105-107.

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