



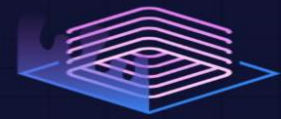
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



**Perspectives on the past and present of women in medicine**

Dr. Tariq Mehmood, Prof. María Rodriguez

Department of Political Science, Lahore University of Management Sciences (LUMS), Lahore

Institute of Political Science, University of Buenos Aires, Buenos Aires, Argentina

**Abstract:**

In recent years, there has been a notable shift in the gender composition of medical colleges in the United Kingdom, with female students now constituting a larger proportion than their male counterparts. This article examines the historical evolution of women's responsibilities in the field of medicine, as well as the present demographic trends within this profession. The data utilised in this study is derived from previous research investigations, as well as ongoing data collection efforts conducted by the Health and Social Care Information Centre and the Department of Health. The areas of concurrent execution: Gender disparities in employment are evident, with notable differences in occupational choices and work arrangements. Specifically, women tend to concentrate in specific areas of medicine and are more inclined towards part-time employment compared to their male counterparts. Issues with achieving consensus: Given the changing demographics of the medical labour market, there is an urgent and crucial need to enhance the level of activity among the current workforce. The development of measures aimed at reducing inequities in employment choice should be pursued by workforce planners, legislators, and Royal Colleges. In addition to conducting research on strategies that can enhance engagement and participation. The present research priorities encompass the subsequent items: Further investigation is necessary to ascertain the potential profitability of both present and future actions within this business.



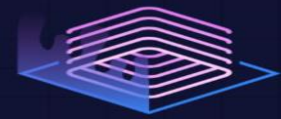
### Citation

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



## Introduction

The historical background of women in the medical profession.

The individuals referred to as midwives, nurses, and healers

Throughout history, women have had a significant part in the field of health and healing, spanning from ancient times to the present. However, the nature of their involvement has been diverse and accompanied by a range of interconnected tensions. The admission of women to medical colleges in the United Kingdom did not occur until the latter part of the 19th century. Consequently, a persistent discrepancy in treatment based on gender and social status has consistently existed. In historical contexts, it was observed that men tended to avail themselves of the services provided by university-trained medical professionals, whilst persons of lower socioeconomic status often sought assistance from female healers, who were commonly referred to as "witches" or "wise women" by some segments of society. The transmission of herbal remedies for medical conditions has been perpetuated across successive generations, accompanied by the accumulation of experiential knowledge and specialised skills. The Church frequently engaged in conflicts with these practises due to perceiving them as a potential challenge to the established medical licence system provided by the Church to doctors who had received education at universities, as well as the religious principles they espoused. The Church expressed apprehension regarding the growing success of "peasant healers" and its potential impact on diminishing reliance on prayer. Consequently, the Church played an active part in disseminating beliefs and practises associated with witchcraft across Europe, so diminishing the perceived legitimacy of women's responsibilities in healing. During the period of the witch hunt, midwifery emerged as the sole clinical speciality that allowed women to practise. This can be attributed, at least in part, to the relatively lower social status associated with midwifery, which acted as a deterrent for male physicians from pursuing this particular discipline. In contrast, the utilisation of obstetric forceps represented a significant



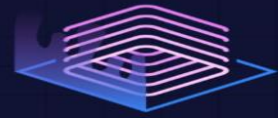
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



advancement in the field of medicine, which garnered the interest of male practitioners due to the prohibition of their utilisation by the exclusively male Barber Surgeon Guild. The decline in the proportion of female midwives can be attributed to two factors: the perception that male practitioners possessed superior technical expertise, and the growing preference among women for obstetricians, sometimes referred to as "man-midwives," who were linked with higher social standing and wealth. During the 19th century, there existed a group of five women who were actively engaged in the field of medicine.

As a result of the limitations imposed on women's employment opportunities throughout the early nineteenth century, a significant proportion of women in the workforce were engaged in occupations such as governesses, housemaids, or nurses, primarily inside the domestic sphere. The number six. Certain women exhibit a strong determination to disguise their true identities in order to engage in professions that have historically been dominated by males. One notable instance involves Hannah Snell, who assumed a male identity and enlisted in the British army with the objective of locating her estranged husband, who had deserted her. The narrative of Dr. James (Miranda) Barry serves as a poignant representation of the extent to which women are willing to strive within the medical profession. After obtaining his medical degree from the University of Edinburgh in 1812, Dr. Barry embarked on a successful career as a distinguished physician. Over the course of several decades, he achieved notable recognition and eventually rose to the esteemed position of Inspector General of Hospitals in the British army. The gender of Dr. Barry was not disclosed until posthumously in 1865. In the nineteenth century, the emergence of "modern medicine" was accompanied by the processes of professionalisation and the perpetuation of male dominance, mostly due to the exclusion of women from obtaining the necessary university-level medical education for professional practise. This era was ushered in by these technological progressions, alongside novel scientific revelations and laboratory methodologies. The exclusion of women from school and the labour force was frequently rationalised based on biological factors.



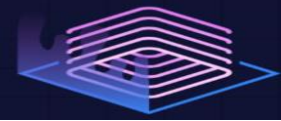
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



In the book "Sex in Education" (cited by Achterberg<sup>5</sup>), Dr. E. H. Clark expressed concerns on the effects of higher education on women. He cautioned that it may lead to the development of disproportionately large brains and underdeveloped bodies, excessive mental activity coupled with weak digestion, a tendency towards abstract thinking, and digestive issues characterised by infrequent bowel movements.

Although the Medical Registration Act of 1858 did not explicitly forbid women from engaging in medical practise, numerous medical establishments, including universities and Royal Colleges, effectively enforced such exclusionary practises by denying female students the opportunity to pursue medical education or participate in the requisite academic examinations. Consequently, the initial female practitioners of medicine in the United Kingdom capitalised on existing legal loopholes inside university systems. One notable example is Dr. Elizabeth Blackwell, who received her education from an American medical institution and achieved the distinction of being the inaugural woman to attain full registration by the General Medical Council (GMC) in the year 1858.

The study conducted by Jefferson et al. (2015) at Pennsylvania State University on May 11, 2016, can be found in Volume 114 of the journal BMB (<http://bmb.oxfordjournals.org/>). Consequently, they were granted permission to enrol under a stipulation that grants women holding foreign medical degrees the opportunity to engage in medical profession within the United Kingdom. In 1865, Elizabeth Garrett Anderson, a female student, successfully obtained a medical degree for her studies in midwifery. Subsequently, the Society of Apothecaries, which subsequently became the British Medical Association, implemented a policy that forbade the admission of women into their educational programmes. Edinburgh encountered comparable limitations. One notable case is Sophia Jex Blake, who was granted permission to participate in medical classes, but encountering significant opposition and hostility from her male peers. The individual in question underwent the identical examination procedures as her male counterparts; but, instead of being



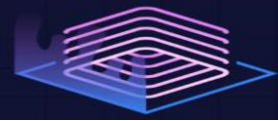
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



awarded a medical degree, she was granted a Certificate of Proficiency. The individual's discontent prompted her relocation from Edinburgh to Berne in pursuit of higher study, culminating in the attainment of a medical degree. Subsequently, she proceeded to Dublin, where she successfully registered with the General Medical Council (GMC).

The 'Enabling Act' of 1875, which ostensibly granted British universities the authority to confer medical licences upon women, coincided with the implementation of more extensive societal changes catalysed by the first wave of feminism. The numerical value provided by the user is 9. Nevertheless, this did not impede institutions from making determinations regarding the inclusion or exclusion of women as prospective students. In 1874, a cohort of resolute and progressive women, spearheaded by Elizabeth Garrett Anderson and Sophia Jex Blake, founded the London School of Medicine for Women. Presently recognised as the Royal Free Hospital School of Medicine, it holds the distinction of being the inaugural medical institution in the United Kingdom to accept and educate women in the field of medicine. In the year 1885, Sophia Jex Blake made her way back to Edinburgh and proceeded to found the Edinburgh Hospital and Dispensary for Women and Children. *The Role of Women in Medicine during the Twentieth Century*

The founding of the first medical schools for women in the early twentieth century led to an increase in the number of women engaged in the practise of medicine. The number of female doctors in England and Wales had a significant increase from 25 in 1881 to 495 in 1911. During the aforementioned historical era, notable social changes were implemented, including the Education Act of 1918 and the Sex Disqualification Act of 1919. These reforms played a significant role in facilitating women's access to professional fields like as medicine. The labour scarcities experienced during World War I had a significant role in facilitating a progressive surge of women's participation in the workforce across diverse occupational sectors. The numerical value of thirteen. During this period, there was a noticeable increase in the number of women pursuing medical education in Britain, driven by the need to address the nation's healthcare requirements in



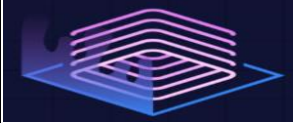
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



light of male enlistment in the military. Due to the restricted admission policies of a limited number of medical colleges, women encountered limited opportunities for advancing their medical studies. In the year 1915, many hospitals in London, namely Kings College Hospital and University College Hospital, initiated the provision of training opportunities specifically targeted at women. During the 1930s, the London School of Medicine for Women played a significant role in the education of around 25% of female medical students in Britain. Until 1944, there were several limitations imposed on women pursuing medical education. However, due to continuous public pressure, a government committee made the decision to allocate public funds exclusively to institutions that permitted the enrollment of a proportionate number of women, specifically suggesting one fifth (Ministry of Health: p 99, 1944 cited in Elston<sup>14</sup>). Although this initial step was perceived as a favorable development in promoting female engagement, these criteria ultimately served as the basis for implementing quotas that restricted the participation of all but the most highly qualified female candidates in medical schools during this period.<sup>14</sup> Following the conclusion of World War II, women experienced limited advancements in their societal standing, as males continued to assume the primary role of providing for their households, hence perpetuating women's financial reliance on men.<sup>15</sup> Women continued to face restrictions in the workplace. In the aftermath of World War II, a significant number of enterprises in Britain, particularly those operating in professional sectors, enforced "marriage bars" which imposed restrictions on women's employment upon marriage or pregnancy. During the period spanning from the 1960s to the 1980s, several initiatives were implemented to enhance the involvement of women in the medical profession and the overall workforce. Against the backdrop of mounting societal pressure to ensure gender equality and the enactment of legislation such as The Sex Discrimination Act, medical workforce planners acknowledged the significance of augmenting the pool of domestically trained doctors and reducing dependence on foreign medical professionals. The aforementioned requirement was met with the emergence of a growing cohort of female physicians commencing in the 1960s. The article titled "Women in Medicine" was published in



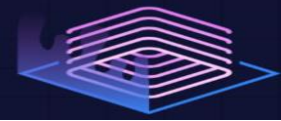
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



2015 in Volume 114, Issue 7. It was accessed on May 11, 2016, at Pennsylvania State University. The article can be downloaded from the Oxford Journals website at <http://bmb.oxfordjournals.org/>. In the 1970s, the system underwent a process of institutionalization and began to prioritise merit-based criteria, including the examination scores of applicants. This shift marked a departure from previous informal practises that allowed for discriminatory practises based on gender and social class. The increase in female applicants can be attributed to the fact that female students were attaining academic performance on par with their male counterparts during that period. Currently, females exhibit superior academic performance compared to males in educational settings, and there is a greater proportion of women who pursue higher education in comparison to men. The number 20. In contemporary A-level education, there exists a more even distribution of academic subjects between male and female students. Specifically, the proportion of female candidates in chemistry examinations is at 48%, while the field of biological sciences has a higher representation of female students, accounting for 56% of total entries. The number nineteen. The aforementioned modifications have led to a rise in the proportion of women pursuing careers in the medical field.

**The present-day medical labour force**

1. Over the past four decades, there has been a substantial rise in the percentage of female applications to medical schools in the United Kingdom. As a result, the number of female medical students has surpassed that of their male counterparts. In 1963, the Universities Central Council on Admissions (UCCA) conducted an analysis of the proportion of male and female applicants in the field of medicine. The findings revealed that women accounted for less than 34% of total applications and just 29% of accepted offers. The number mentioned is 21. Between 1980 to the present, there has been a consistent and incremental growth in the representation of female medical students, with a notable gain of 10% every decade. In recent years, there has been a significant increase in the proportion of women obtaining medical degrees (see Figure 1). However, there remains a disparity since the



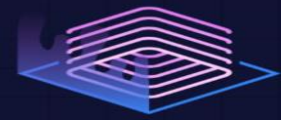
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



proportion of women actively practicing medicine has not experienced a corresponding growth. In the United Kingdom, the current proportion of women in the medical workforce stands at 47%.According to Figure 1, the distribution of those working in primary care is greater than those working in secondary care, with a proportion of 2.23.

It is anticipated that the proportion of women in the medical workforce would exceed 50% by the year 2017.The gender mix of the medical workforce is undergoing a transformation, mirroring similar trends observed in other professional sectors within the United Kingdom. The legal profession, similar to the field of medicine, has undergone a significant transformation from a historically male-dominated industry that imposed restrictions on women's entry, to a state of near parity, with women today constituting 46% of legal practitioners. The number 33.

Nevertheless, there persists a gender disparity in several professional domains, with men outnumbering women. The engineering and technology sectors exhibit a notable under representation of women, while a substantial majority of architects, specifically 85%, are aged 35 or over. In this study, we aim to investigate the effects of climate change on biodiversity in tropical rain

The medical workforce worldwide is experiencing a progressive shift towards achieving gender balance. The World Health Organization (WHO) is responsible for gathering global data pertaining to the proportion of female physicians across different nations. While there may be variations in the reference year and data quality, this analysis offers a valuable comparative assessment of Europe and other nations that have a workforce of over 20,000 physicians. The data was predominantly gathered during the early 2000s, revealing that, on average, 40% (SD 8.8) of women in Europe were employed as physicians. This figure represents the percentage of female physicians employed in England in the year 2002, which was 37%.The range of values is between 26 and 27. In regions beyond Europe, the proportion of women engaged in the medical profession





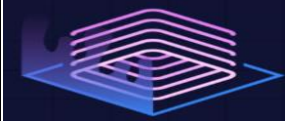
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



exhibited a notable disparity, with a median of 33% and an interquartile range of 24-36%. However, it is important to acknowledge that this data is influenced by the disproportionately low representation of female doctors in Bangladesh (24%), Nigeria (20%), and Japan (15%).

**The provision of primary and secondary healthcare services in the United Kingdom.**

The prevalence of primary care physicians is on the rise, and this phenomenon can be attributed almost entirely to the overall growth in the population of general practitioners (GPs). From 1988 to 2013, there was a rather stable trend observed in the number of male general practitioners, with figures ranging from 20,915 to 19,801. In contrast, the number of female general practitioners had a notable increase, rising from 6,505 to 20,435 over the same period. This is illustrated in Figure 1, which presents the proportion of female physicians in primary and secondary healthcare settings throughout the specified duration.

Although the number of male and female general practitioners (GPs) is almost the same, there are variations in the sorts of contracts they have. There is a higher likelihood for males to assume the role of GP principals or partners within a GP practise, as opposed to being salaried GPs who work under contractual arrangements within the practise. This phenomenon underscores the presence of vertical gender segregation within the field of medicine, a concept used by sociologists to elucidate the disparity in positions of power and prestige between women and men inside organizations, despite possessing comparable levels of talent and experience. Over the past few decades, there has been a noticeable rise in the workforce participation of both genders in secondary care. Nevertheless, it is evident that the pace of increase among women has been slightly higher in recent years. The sequence of numbers provided by the user includes the integers 23, 27, 29, and 31.

The topic under consideration pertains to the progression of one's professional trajectory and the equitable treatment of individuals across genders within the context of career development.



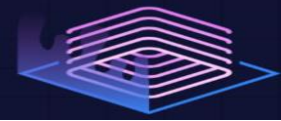
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



The issue of women being underrepresented in medical leadership roles has been extensively discussed by several authors.

In 2004, Dame Carol Black, the former president of the Royal College of Physicians, initiated a discussion by expressing apprehension regarding the potential decline in the medical sector due to the decreased inclination of women to assume leadership positions. The number 31. Numerous scholars have posited the notion that female physicians have significant challenges in their pursuit of higher-level jobs within the medical field, often referred to as a "glass ceiling." The numerical expression "37-33" represents the subtraction operation between the numbers 37 and

Nevertheless, the increasing presence of women in the medical profession in England seems to be gradually diminishing gender disparities in career progression, as indicated by the declining gaps in career grades among women as they rise to higher-ranking positions, as illustrated in Figure 2. The slower progression towards higher-level professions, such as consultant posts, results in a cohort impact that contributes to a decelerated trend. According to Taylor et al. (38), the differential career progression between male and female doctors may not primarily stem from gender discrimination. Instead, it could be attributed to factors such as women's higher likelihood of taking breaks from work to care for their family or opting for part-time employment. The inclusion of full-time versus part-time employment in their cohort studies of medical students resulted in a significant reduction of gender differences in career progression. Moreover, there was no observed statistically significant disparity in professional advancement between male and female physicians who consistently maintained full-time employment. The numerical value provided by the user is 38.

**Engaging in part-time employment**

The greater degree of flexibility inherent in primary care may serve as a contributing factor to the higher proportion of female physicians in this field, therefore elucidating the substantial gender



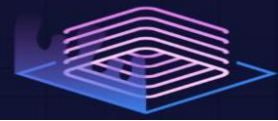
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



disparities observed in part-time employment rates within this domain. When comparing the work schedules of male and female general practitioners (GPs), it is seen that a significantly higher proportion of female GPs, namely 42%, choose to work part-time, whereas only 18% of their male counterparts do so. Figure 3 illustrates the disparities in full-time equivalents based on gender.

Nevertheless, there seems to be a gradual rise in the duration of hours worked by female general practitioners. Specifically, in 2003, the average weekly workload stood at 30 hours, whereas by 2013, it had escalated to 32 hours.<sup>2</sup> Despite an observed increase in the number of women engaging in part-time hospital medicine, there has been no corresponding increase in the proportion of female hospital physicians.

The number 114. On May 11, 2016, a study was conducted at Pennsylvania State University, as documented in the publication available at <http://bmb.oxfordjournals.org/>. The data was obtained through downloading. The percentage of individuals engaged in part-time employment has experienced a notable decrease throughout the period from 1975 to 2013, declining from 39% to 24%. The article titled "Women in Medicine" is published in Volume 22, Issue 29 of the journal. A similar trend has been observed in the demographic of male hospital physicians, with a significant decrease in the proportion of males engaged in part-time employment, dropping from 35% in 1975 to 8% at now. The numbers 22 and 29 are being referred to.

**The potential outcome of the 2003 consultant may have resulted in this.**

Figure 2 depicts the proportion of female physicians across various hospital grades throughout the years 1975, 1992, and 2013. The numbers are shown in the form of boxes. In the United Kingdom, the designations "House Officer" and "Senior House Officer (SHO)" have been substituted by the terms "foundation years" (FY1 and FY2). After the successful completion of the foundation years, trainees go to the registrar grade and make a selection on their area of specialisation. The statistics presented here are blended due to the lack of differentiation in historical data between registrar,



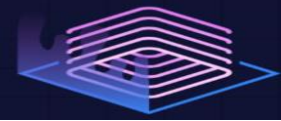
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodriguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



senior registrar, and staff grades. Hospitalists, clinical assistants, associate specialists, and speciality physicians are collectively categorised as medical practitioners known as "Specialist and Associate Specialist (SAS) doctors." In the medical profession, the pinnacle rank attained by physicians is that of a consultant. The sources of information include the Health and Social Care Information Centre and the Department of Health. The numbers provided are 23 and 27.

Figure 3 illustrates the full-time equivalent (FTE) of general practitioners (GPs) categorised by gender in the year 2013. The Health and Social Care Information Centre is the designated source of information. The user's text is too short to be rewritten in an academic manner.

On May 11, 2016, a study conducted by L. Jefferson et al. (2015) was presented at Pennsylvania State University (Vol. 114). The user accessed a document from the website <http://bmb.oxfordjournals.org/> on a contractual arrangement that permits full-time National Health Service (NHS) consultants to engage in private practise while maintaining their full-time employment commitment, which entails a minimum of 10 "programmed activities" consisting of four hours per week. The numerical value provided by the user is 38.

Despite the prevalence of full-time schedules among hospital doctors in contemporary times, there is a discernible trend wherein doctors in more advanced stages of their professions are opting for part-time work arrangements. This shift may perhaps indicate a growing inclination towards exclusive private practise reserved to consultant-level individuals. The literature has examined the motivations for part-time work with regards to gender disparities. Female physicians, as an illustration, have documented diminished levels of assistance from their spouses in regards to child-rearing and household duties, which has a consequential impact on their work schedules and career advancement. The numerical values provided are 41 and 40.

A phenomenon referred to as "deferred parenthood" has been documented in several research [1-25]. This trend involves women intentionally delaying their plans to start a family in order to



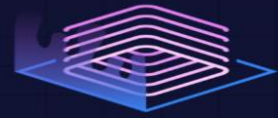
*Citation*

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



prioritise their professional advancement in the field of medicine. Based on the present labour data, it can be observed that several variables contribute to the expansion of gender differences in part-time work as doctors progress in their careers. The number 22 is the subject of discussion. An evident disparity exists in the distribution of part-time work among career grade doctors, including consultants, staff grades, associate specialists, and specialty doctors, with a notable gender imbalance. The proportion of women holding part-time employment in the same career level is nearly three times higher than that of males. An analysis of the consultant grade, the highest level of doctor grade commonly known as "attending" doctors in the United States, reveals a consistent pattern: nowadays, 33% of female consultants engage in part-time work, whilst the corresponding figure for male consultants stands at 10%. The number 22 is the subject of discussion. Based on empirical research, it is plausible to interpret this phenomenon as a cohort effect, which is anticipated to diminish when a greater number of women progress beyond the childbearing stage, during which part-time employment is more prevalent, and attain higher professional ranks within the medical field. The user's text is too short to rewrite in an academic manner.



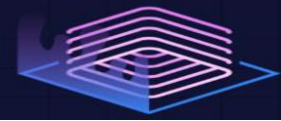
### Citation

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



### References

1. Elston MA. *Women and Medicine: The Future*. Royal College of Physicians, London, 2009.
2. Health and Social Care Information Centre. *General and Personal Medical Services, England: 2013 Workforce Statistics*. Department of Health, London, 2013.
3. Bourdillon H. *Women as Healers; A History of Women and Medicine*. Cambridge University Press, Cambridge, 1988.
4. Ehrenreich B, English D. *Witches, Midwives, and Nurses: A History of Female Healers*. The Feminist Press, New York, 1973.
5. Achterberg J. *Woman as Healer: A Comprehensive Survey From Prehistoric Times to the Present day*. Rider, London, 1991.
6. Riska E. Introduction. In: Riska E, Wegar K (eds). *Gender, Work and Medicine: Women and the Medical Division of Labour*. Sage Publications, London, 1993.
7. Hurwitz B, Richardson R. Inspector General James Barry MD: putting the woman in her place. *BMJ* 1989;298:299–305.
8. Witz A. *Professions and Patriarchy*. Routledge, London, 1992.
9. Abbott P, Wallace C, Tyler M. *An Introduction to Sociology: Feminist Perspectives*, 3 edn. Routledge, London, 2005.
10. Blackmore S. *Elizabeth Blackwell: the first woman to qualify as a doctor in America*. The Wellcome Trust, 2013.
11. *The Education Act*. London, 1918.
12. *The Sex Disqualification Act*. London, 1919.
13. Giddens A. *Sociology*, 5th edn. Polity Press, Cambridge, 2006.
14. Elston MA. Women doctors in a changing profession: the case of Britain. In: Riska E, Wegar K (eds). *Gender, Work and Medicine: Women and the Medical Division of Labour*. Sage Publications, London, 1993.
15. Jackson S. *Sociology Lecture: Gendered Work - Paid and Unpaid*. University of York, York, 2011.
16. Jacobsen JP. *The Economics of Gender*, 3 edn. Blackwell Publishing, Oxford, 2007.
17. Stationery Office. *The Sex Discrimination Act*. Stationery Office, London, 1975.
18. Department for Education and Skills. *Gender and Education: The Evidence on Pupils in England*. Department for Education and Skills, London, 2007.
19. Ofsted. *Girls' Career Aspirations*. Ofsted, Manchester, 2011.
20. Thompson J, Bekhradnia B. *Male and Female Participation and Progression in Higher Education*. The Higher Education Policy Institute, Oxford, 2009.
21. BMA. *Equality and diversity in UK medical schools*. BMA Equal Opportunities Committee, London, 2009.



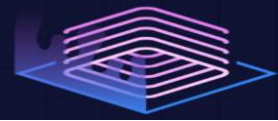
**Citation**

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



22. McManus IC. Medical school applications—a critical situation. *BMJ* 2002;325:786–7.
23. Health and Social Care Information Centre. NHS Hospital and Community Health Services: 2013 Workforce Statistics in England. Department of Health, London, 2013.
24. Nicolson D. Demography, discrimination and diversity: a new dawn for the British legal profession? *Int J Legal Prof* 2005;12:201–28.
25. World Health Organisation. Global Atlas of the Health Workforce: Gender Distribution of Selected Health Professions. World Health Organisation, Geneva, 2006.
26. NHS Information Centre. NHS Staff 1995–2005 (General Practice). NHS Information Centre, London, 2006.
27. NHS Information Centre. NHS Hospital and Community Health Services: Medical and Dental Staff: England 1999–2009. NHS Information Centre for Health and Social Care, Workforce and Facilities, 2010.
28. NHS Information Centre. “NHS Staff 2000–2010 (General Practice)”. NHS Information Centre for Health and Social Care, London, 2011.
29. Department of Health. Medical and Dental Workforce Statistics: Historical Data From 1975 to 2002. Department of Health, London, 2007.
30. Health and Social Care Information Centre. NHS Hospital and Community Health Services: 2011 Workforce Statistics in England. Department of Health, London, 2011.
31. Health and Social Care Information Centre. NHS Hospital and Community Health Services: 2012 Workforce Statistics in England. Department of Health, London, 2012.
32. Laurance J. The medical timebomb: too many women doctors, 2004.
33. Levinson W, Lurie N. When most doctors are women: what lies ahead? *Ann Intern Med* 2004;141:471–4.
34. BMA. Women in Academic Medicine: Challenges and Issues. BMA Medical Academic Staff Committee, London, 2004.
35. Office for National Statistics. Labour Force Survey: Employment Status by Occupation and Sex. Office for National Statistics, London, 2010.
36. Carnes M, Morrissey C, Geller SE. Women’s health and women’s leadership in academic medicine: hitting the same glass ceiling? *J Womens Health (Larchmt)* 2008;17:1453–62.
37. Kvaerner KJ, Aasland OG, Botten GS. Female medical leadership: cross sectional study. *BMJ* 1999;318:91–4.
38. Taylor KS, Lambert TW, Goldacre MJ. Career progression and destinations, comparing men and women in the NHS: postal questionnaire surveys. *BMJ* 2009;338:b1735.
39. Department of Health. Revised Terms and Conditions for NHS Consultants. Department of Health, London, 2003.
40. Gjerberg E. Women doctors in Norway: the challenging balance between career and family life. *Soc Sci Med* 2003;57:1327–41.



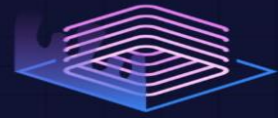
*Citation*

Dr. Tariq Mehmood, & Prof. María Rodríguez. Perspectives on the past and present of women in medicine . *Advance Social Science Archive Journal*. Retrieved from <http://assajournal.com/index.php/36/article/view/26>

*Advance social science archive journal*

*E(ISSN)* [3006-2500](#)

*P(ISSN)* [3006-2497](#)



41. Jovic E, Wallace JE, Lemaire J. The generation and gender shifts in medicine: an exploratory survey of internal medicine physicians. *BMC Health Serv Res* 2006;6:55.
42. Dumelow C, Littlejohns P, Griffiths S. Relation between a career and family life for English hospital consultants: qualitative, semi-structured interview study. *BMJ* 2000;320:1437–40.
43. Goldacre MJ, Davidson JM, Lambert TW. Doctors' age at domestic partnership and parenthood: cohort studies. *J R Soc Med* 2012;105:390–9.
44. Reed V, Buddeberg-Fischer B. Career obstacles for women in medicine: an overview. *Med Educ* 2001;35:139–47.
45. Willett LL, Wellons MF, Hartig JR, et al. Do women residents delay childbearing due to perceived career threats? *Acad Med* 2010;85:640–6.
46. Crossley T, Hurley J, Jeon S-H. Physician labour supply in Canada: a cohort analysis. *Health Econ* 2009;18:437–56.
47. Petrides KV, McManus IC. Mapping medical careers: questionnaire assessment of career preferences in medical school applicants and final-year students. *BMC Med Educ*