**The Female Psychiatrist in the 21st Century: A Vision of the Future**

*“If society will not admit to women’s free development, then society must be remodeled”* - Elizabeth Blackwell, first female physician registered with the British Medical Council

Dr Eleanora Fleury (1860 – 1940) is noted in history as a woman of firsts. Not only holding the accolade of being the first female medical graduate from the Royal University of Ireland, Dr Fleury also went on to become the first female member of the Royal College of Psychiatrists in 1894, some 53 years after the organization was founded (The Royal College of Psychiatrists). Whilst there is relatively little in circulation in terms of her biography, Dr Fleury featured recently in an article entitled “‘On the inside sitting alone’: pioneer Irish women doctors” (Bewley, 2005). This title succinctly describes the milieu in which Dr Fleury practiced Psychiatry; acceptance into a heretofore male-only domain (and a begrudging acceptance at that, her initial nomination to the College having been outvoted (Collins, 2013)) but existing very much as a lone female figure, undoubtedly feeling her separateness starkly. For Dr Fleury, her goals must certainly have included the inclusion of more women into the field of Psychiatry during the 20th century.

Fast-forward 120 years, and thanks in no small part to pioneers like Dr Fleury, female doctors are no longer “on the inside sitting alone”. Psychiatry now holds more female than male trainees both in the US (Association of American Medical Colleges, 2015) and in the UK, where women make up 51% of those training in or practicing Psychiatry under the age of 40. (General Medical Council, 2017). Societal impressions are catching up with this swing in the pendulum; anecdotally there are less glances of surprise from patients when they learn that their psychiatrist is not the stereotyped 50-something male with greying facial hair and a Freud-inspired tweed coat replete with elbow patches. Whilst women may be represented in equitable numbers within the profession, however, one must wonder whether our voices are represented to the same degree as our male counterparts in terms of shaping the nature of psychiatric practice and the direction of services that provide mental health care. As female psychiatrists in the 21st Century, have we evolved from “on the inside sitting alone” to on the inside sitting quietly?

An examination of the role of women in modern Psychiatry must begin first with an inspection of the pillars in which we practice modern Psychiatry. As a starting point, it is interesting to note that the biomedical model of illness has been suggested to be inherently patriarchal in nature (Sharma, 2019). It is argued that the markers of recovery from mental illness within this model, which include rationality of thought and return of activity, are traditionally male attributes, therefore placing female patients as a deviation from this established “norm” from the outset. Whilst it is undoubtedly reductive to assign characteristics of rationality and productivity to men, not to mention bolstering archaic gender stereotypes, this theory challenges us to consider the origin and purpose of the scaffolding theories of psychiatric practice.

From an ethical perspective, modern Psychiatry holds the “4 Principles” model (Beauchamp & Childress, 2001) of bioethics as one of its central tenets, juxtaposing these principles of non-maleficence, beneficence, autonomy and justice against the more paternalistic “best interests” principles enshrined within mental health legislation. Autonomy as a concept emerged in bioethics in the 1970s as something of a paradigm shift; the will and preference of the individual became sacrosanct, trumping all else. There is a body of evidence emerging, however, around the concept of relational autonomy. This moves away from the individualist nature of traditional autonomy and more toward an autonomy that recognizes the existence of the individual within a wider human network; relational autonomy “aims to maintain the essential aspect of autonomy… [and] incorporate insights of a socially embedded notion” (Breslin, 2005). This notion of a more interconnected approach to care is rooted in feminist theory (van Bogaert & Ogunbanjo, 2009). Whilst there exists a diversity of feminist theories, the concept of societal cohesiveness and care span most individual ideologies. Arguably no branch of medicine is more requiring of the integration of medical care and the patient’s social context than Psychiatry.

Whether or not women in Psychiatry identify as feminists, there is undoubtedly an onus on us to challenge the theoretical structures in which Psychiatry is currently conceptualized and become actively involved in advancement of the understanding of mental illness. We know that understanding of the causes of mental illness is ever-changing; during Dr Fleury’s time, the prevailing theory of focal infection causing mental illness led to removal of everything from teeth to colons - who can predict what the prevailing theories around Psychiatry may be at the end of this century? Whether that be through involvement in an ICD specialist group or teasing out genetic loci of susceptibility, it is imperative that women are involved in the evolution of the understanding of mental illness, and by extension in the interventions that are utilized to treat it.

Advocacy is a crucial role for psychiatrists, regardless of gender. Advocating for individual patients, for patient groups and for resources is much a part of the work of a psychiatrist as writing a prescription. Whilst it is perilous to subscribe to the concept that only female psychiatrists should treat female-preponderant conditions, we are perhaps in an advantageous position for advocating for female patients. One such area is that of perinatal mental health. In 2019, there were over 640,000 live births in England and Wales (Office of National Statistics, 2020). If one takes the generally-quoted rate of 10-20% perinatal mental illness, this equates to approximately 64,000 – 128,000 women in these regions experiencing significant mental health challenges. The NHS announced in 2016, as part of its “Five Year Forward View for Mental Health”, an investment of £365 million in perinatal mental health over the 2016 – 2021 period; assuming a birth rate similar to 2019 and a conservative rate of 10% mental illness, this figure breaks down to £1, 100 per woman. By contrast, the average cost of treatment of prostate cancer was £3, 300 per patient in the UK in 2010, a figure that has presumably risen in the last decade (Laudicella, Walsh, Burns, & Smith, 2016). There is of course a myriad of differences between these two conditions, but they are both biological sex specific. Arguably, the frequency and significant morbidity associated with perinatal mental illness would indicate that the investment should be interchanged. These figures serve to highlight that, in under-resourced areas, even when investment has occurred, there is ongoing requirement for advocacy in order to ensure improved services for female patients.

Similar to perinatal mental illness and its profound impact not just on the woman but on her children and extended family, gender-based violence has been spotlighted as something of a global epidemic. Over 1.3 million incidences of domestic violence were reported in England/Wales in 2019, an increase of 24% compared to the previous year; data for 2020 is indicating ever-increasing rates of violence in the context of the Covid-19 pandemic. Recent research has demonstrated that women exposed to domestic violence are 2.6 times more likely to experience a significant mental health problem compared to those who have not (Chandan, Thomas, Bradbury-Jones et al., 2020). Women with psychiatric and psychological sequelae of domestic violence often present to mental health services that are ill-equipped to manage this in a specialized way; perhaps in the same way that the United Nations and European Union are embarking on an initiative to end violence towards women and girls, we as female psychiatrists have a role in advocating for the provision of dedicated services to support those who are victims of gender-based violence.

Advocating for gender equality in treatment of mental illness also includes an awareness of the inclusion of women in clinical trials, as well as consideration of gender-specific effects with new treatments. A 2007 study revealed that 15% of clinical trials in that year did not publish a gender breakdown of participants, whilst 50% of the trials did not complete any analysis of outcome by gender (Weinberger, McKee, & Mazure, 2010). Awareness of gender bias is not confined solely to clinical trials. A study investigating the construction and portrayal of gender in advertisement of psychotropic medication in a medical publication for healthcare professionals found that women were more likely to be depicted as passive, with incomplete bodies and to be looking out at their audience; these depictions are regarded as signifying inferiority, physical deficiency and that women are defined by the gaze of others (Breathnach, 2013). Women were portrayed in stereotypically feminine ways in their clothes (dresses and long hair) and in roles/activity (shopping or parenting). Furthermore, the study demonstrated profound gendering of illnesses; women were shown as users of psychiatric drugs for depression in 92.3% of advertisements and for generalised anxiety disorder in 80%. No doctor immune to the subtle effects of advertising, and arguably such blatant sexism in advertising disadvantages both sexes; given the prevalence of suicide in young males, for example, depicting depression as a “female” disorder is detrimental. There is continued need for education of our colleagues in discarding any pre-conceived ideas about mental illness and gender, treating each patient with the most suitable and individualised intervention.

When considering the question of women in Psychiatry in the 21st century, one must consider the fact that, in the 80 years left in this century, there will likely be significant changes in the way in which mental health care is delivered. It is essential that women are involved in this process in leadership roles with decision-making capabilities. These may be decisions that directly affect career pathways, such as flexible/less than fulltime working hours and workforce planning strategies, but cannot be limited to these solely; female psychiatrists must be involved in policymaking in all areas pertaining to the practice of and delivery of mental health care. The challenge lies in how to ensure women in healthcare obtain leadership roles. Empowering women to develop managerial skills through educational programs is an essential part of this process. Peer support, through mentorship programs or organisations such as the Health and Care Women’s Leaders Network, provides a platform for shared learning and collaboration, as well as dissemination of information.

Changing a culture within any organisation must come from the top and percolate downward; this translates into organisations having policies and strategies that go beyond paying lip service to empowering women and that result in meaningful change with respect to gender parity. Whilst progress in this regard is being made within the NHS, an organisation in which 77% of the total workforce is female, it has nonetheless failed to achieve the goal set out in the 2017 “NHS Women on Boards 50:50 by 2020”. A report in September this year found that just 44.7% on NHS Trusts’ boards in England were female. Perhaps more concerningly, the report found significant disparity between Trusts; some recorded 77.8% of senior roles being held by women whilst others a mere 15.4%. Particular senior roles also appear to be lagging; female Chief Financial Officers have fallen to 25.3%, whilst the percentage of female Medical Directors stands at 29%. Strategies used within the business and technology fields may be useful in terms of planning how best not only just to promote women to leadership roles but also ensure that their input carries as much weight as their male counterparts; remaining focused on ensuring continued gender parity has never been more important than in the post-Ruth Bader Ginsberg world we now find ourselves in. There is solace perhaps in the knowledge that our female counterparts within these industries have far from a level playing field also; US-based General Motors (GM) Corporation, which was identified as the number one company globally in terms of gender ratio, leadership, equal pay and shared parental leave policy, currently has for the first time in its history a female CEO. Whilst Mary Barra obtained this role in 2014, the organisational changes required to achieve this accolade presumably predated her appointment; perhaps what this demonstrates is that organisations do not necessarily need to have a female at the highest level of leadership to begin the process of making meaningful change to gender inequality.

As a profession, Psychiatry is gradually and increasingly recognizing the central role that female psychiatrists play in the delivery of mental health care. Dame Fiona Caldicott became the first female President of the Royal College of Psychiatrists in 1993, 99 years after Dr Eleanora Fleury became the first female member, whilst Professor Wendy Burn recently completed her tenure as President, the fourth woman to hold this title in the College’s 179-year history. The challenge that faced Dr Fleury is no longer the challenge facing women in Psychiatry in the 21st century in that we form as much a part of the workforce as our male colleagues do. The obstacle therefore for our generation is in ensuring that we move beyond purely clinical roles and into those that will allow us to shape future understanding of Psychiatry and effect how mental health care is delivered. Our goal as women in Psychiatry for this century, having long surpassed the “on the inside sitting alone” moniker, should perhaps be “on the inside sitting at the top”.

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