Full-time women general practitioners — an invaluable asset

JUDITH HOOPER

SUMMARY. It has been said that women doctors do not fulfil the same role as men doctors in general practice. This is inaccurate as previous studies of workload in general practice have not excluded from the analyses women principals who are part time, that is, have a less than full profit share at parity. In a postal questionnaire to 501 women principals 308 (62%) replied, of whom 143 (46%) were full time with respect to profit share. Respondents were asked to record aspects of workload over a four-week period for themselves and three of their full-time male partners. Analysis of their responses showed that they did an equal workload to their full-time men partners in terms of number of surgeries, length of surgeries and number of home visits. Equal numbers of full-time women did out-of-hours work as their male partners and the number of nights and weekends on-call as well as use of deputies were similar. The analysis also showed that full-time women did more specialized clinics than men, thus emphasizing the special role of women doctors in preventive care.

Introduction

The number of women medical students has been steadily rising so that in 1987 45% of medical entrants were women (General Medical Council, personal communication). Although general practice has become a more popular career choice during the 1980s, there is still a widespread impression that women cannot 'fulfil the same role as men doctors'. This is exemplified in the DHSS/GMSC workload survey which implied that women do not fulfil an equal commitment to their men colleagues; the report stated that women general practitioners did 85% of the men general practitioner's workload, but omitted to state the women's profit share. This lack of knowledge about profit share and workload is a criticism also expressed by Cooke and Ronalds, in their comparison of workload between female and male principals.

It is usually agreed that women have a number of conflicts between their own careers, their families and the careers of their spouses. Martin recently stated that the majority of women 'need to combine work with domestic commitments on a long term basis'. The likelihood that women doctors will require maternity leave may deter some men principals from considering women as partners. The competition for posts in general practice and these conflicts may delay or deter some women from pursuing careers at all.

Conversely it has been said that general practice is especially suited to the female temperament, owing to the types of patients seen, the problems they present and the increasing emphasis on care and counselling. There is evidence of differences in patterns of work between female and male principals, particularly with respect to women's problems and certain types of preventive care. This may be appreciated by patients but the women doctor's colleagues may consider these are 'softer' options than the average surgery work. This may undermine the status of the woman general practitioner within the partnership.

The aim of this study was to compare the workload of women and men principals with a full profit share, in a wide range of practices. This was done after identifying and excluding those women principals who had a less than full profit share at parity.

Method

Between September 1986 and July 1987 a postal questionnaire was sent to all women principals identified from the family practitioner committee lists of the Northern and Oxford regions. Two reminders were sent at intervals of four weeks, the second enclosing another copy of the questionnaire. The questionnaire was anonymous (coding being used to identify the initial non-respondents). Respondents were asked to indicate whether they were full time (full profit share at parity), part time (less than full share at parity) or salaried. The questionnaire asked about year of qualification, number of years as a principal, postgraduate training and qualifications, sex and status of other doctors in the practice, practice list size, partnership agreements and maternity leave arrangements.

Respondents were asked to record over a four-week period the number of surgeries they did per week, the intended and actual length of surgeries (to the nearest 15 minutes), the number of home visits and the number and type of specialized clinics they did. They recorded the same information for all their full-time men partners up to a maximum of three. When there were more than three partners information was recorded for the doctor who did most sessions in the practice, the one who did least and one in between.

Out-of-hours work is a complicated subject to analyse as there are great variations in local arrangements, including the availability of deputizing services. Respondents recorded how many weekday nights and weekends were covered by them, and by their full-time men partners and, if relevant, an external deputizing service. For each respondent the number of nights on call over the four-week period were divided by the mean number for all her men partners to give a ratio. A similar ratio was calculated for the number of weekends on call over a 12-week period. The number of nights over four weeks and the number of weekends over 12 weeks that a deputizing service was used enabled similar ratios to be calculated for use of deputizing services.

Respondents were also asked about practice business arrangements, the structure of practice meetings and involvement with financial decisions. Finally, the women were asked to give any comments about their men partners' attitudes towards them.

The data were analysed using the SPSSX package.

Results

Out of 2815 general practitioner principals in the two regions 501 (18%) were identified as women (257 in the Northern and 244 in the Oxford regions). After the second reminder 308 (62%) had replied legibly, of whom 143 (46%) identified themselves as full-time principals working in group practices. These formed the study group. Of the rest 146 (47%) were identified as part time, 12 (4%) were single-handed and seven (2%) were salaried.
Thirty six per cent of the full-time respondents had been principals for less than five years and 32% were in training practices.

Workload
Daytime. The surgery workload analysis (excluding specialized clinics) showed no statistical differences between the respondents and their partners (Table 1).

Table 2 clearly shows that considerably more of the women respondents did specialized clinics than in the case of their partners, especially well-woman clinics. There were very few respondents whose practice did other types of clinic, for example diabetic. The number of specialized clinics per month for respondents and their partners were similar for those who did them (Table 2).

Out-of-hours. There were no statistically significant differences between the women respondents and their men partners in the proportions doing weekday nights and weekends on call (Table 3). There were also no differences in the ratio of nights and weekends on-call between women and their partners. The mean ratio of number of nights on-call for the women who did nights compared with their partners was 1.02 (standard deviation 0.16) and for the women who did weekends compared with their partners the ratio was 0.99 (0.08). Twenty three women used a deputizing service on weekday nights and 19 at weekends compared with 44 and 46 for their partners respectively. For the number of weekday nights a deputizing service was used by women compared with their partners, the ratio was 1.00 (0.07) and for the number of weekends the service was used 1.05 (0.23).

A number of respondents from one area commented on their involvement in the local cooperative service.

Practice administration
The majority of respondents (74%) had written partnership agreements and for both training practices and practices with a part-time partner of either sex this rose to 87%. However, only 44% had maternity clauses (55% in training practices). Of the 55 without maternity clauses, 38% had qualified after 1972. Many of the respondents described their maternity leave arrangements, for example the practice covered her leave entirely themselves or the practice treated the locum costs in the same way as they did for sick leave or the locum was paid for entirely by the woman.

Some practices paid vocational training and seniority allowances to the individual partner and a similar number paid these into the practice accounts. Item of service fees were paid into the practice by 76% of respondents. A payment for employing someone to answer the telephone was made to 35% of the respondents but to 52% of their partners. The respondents commented that this was often due to the different tax situations of the spouses of the respective partners.

Sixty six (46%) of the respondents were practising in premises rented from outside the practice, for example, the health authority. Only eight of the remainder did not have a share in the property because the property was rented from one partner only. Of the respondents who had a share in the property only two did not have a full share.

One hundred and thirty respondents were in practices that had practice meetings. Thirty four (26%) of these respondents never chaired meetings. Five felt unable to express an opinion at practice meetings, of whom four were established principals, that is in practice for more than five years. Fifteen (12%) felt their opinions did not carry equal weight, of whom nine had been principals for more than five years.

Five of the 143 respondents (3%) were not involved in financial decisions, four being established principals. Seven (5%) were unable to sign cheques (three being established principals). Twelve respondents did not see the practice's accountant, four of them established principals, although all had access to the accounts.

Discussion
The proportion of women general practitioners in the regions and of those who were full time and part time were similar to national figures. This survey has shown that the full-time women principals had the same workload both day and night as their full-time men partners. In addition, considerably more

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**Table 1. Mean daytime workload of women principals and their full-time men partners.**

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD) number of surgeries per 4 weeks</th>
<th>Mean (SD) intended length of surgeries (hours)</th>
<th>Mean (SD) actual length of surgeries (hours)</th>
<th>Mean (SD) total time in surgery (hours per 4 weeks)</th>
<th>Mean (SD) number of visits per 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women respondents (n = 143)</td>
<td>30.6 (6.9)</td>
<td>1.84 (0.94)</td>
<td>2.23 (1.16)</td>
<td>68.2 (25.1)</td>
<td>73.2 (43.3)</td>
</tr>
<tr>
<td>Men partners (n = 361)</td>
<td>30.4 (7.5)</td>
<td>1.82 (0.93)</td>
<td>2.14 (1.07)</td>
<td>65.1 (22.4)</td>
<td>74.1 (43.4)</td>
</tr>
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SD = standard deviation.
women did specialized clinics. This is to be expected in the case of well-woman clinics where four times as many women as men took clinics, but it is more surprising that 47% more women took baby clinics and 28% more took antenatal clinics. A number of women also commented that they did such preventive work within ordinary surgery time. This fulfils the unmet need previously described by Cooke and Ronalds and emphasizes the particular role perceived by women general practitioners. Item of service fees included activities usually covered by such clinics and these were paid to the practice by most respondents, thus generating income for their partners.

Less than half of the respondents had maternity clauses; 38% of these were women still of childbearing age. If we are to encourage women to enter general practice then surely they are entitled to the same maternity benefits as in other careers, and thus maternity arrangements should be paid for, with no loss to the practice. This could be changed by amending the inadequate regulation covering maternity leave.

Length of time as a principal had some effect on status and decision making within the partnership but this may apply irrespective of sex. One third of the respondents specifically commented that they were quite content having equal shares in all aspects of the practice, and this was particularly true for four women who had resigned part-time posts owing to perceived exploitation.

A number of criticisms could be made of the methods used in this study. Length of surgeries was felt to be a more accurate indicator of workload than consultation rate, although both measurements have disadvantages. The results reflect the perception of the respondents and not of their partners. Respondents were asked only about practice workload that directly involved patient care and not time spent on correspondence, staff matters, financial business, and so on. These aspects are complex to assess as there is so much variation between practices.

The study shows, however, that it is inaccurate to assess the workload of women principals without knowing their profit share at parity. General practice has a flexible contract to accommodate differing needs within practices, for example committee work, teaching, special interests and so on. This can allow flexibility for both women and men to compromise between general practice, other professional interests and their families. 'We have arrangements allowing differing commitments and keep finances, I think, fair' commented one respondent.

This paper dispels the myth that women cannot provide a full role in general practice. In fact by their extra contribution to specialized clinics in addition to a normal surgery workload, women fulfill a broader role in preventive and continuing care. In 1980 the tenth report of the doctors and dentists' review body commented that the Joint Evidence Committee had stated 'while the profession welcomed women general medical practitioners, considerations such as family commitments and a reluctance to practice in certain areas meant they could not in all respects fulfill the same role as men doctors'. Perhaps it is male general practitioners who do not in all respects fulfill the same role as women doctors.

References
1. Review body on doctors and dentists' remuneration. 18th report (Cm 358). London: HMSO, 1988; paragraph 79.
2. Review body on doctors and dentists' remuneration. 10th report (Cm 7903). London: HMSO, 1980; paragraph 74.

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