Women general practitioners in Oxfordshire

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SUMMARY. The proportion of women medical students is increasing as is the proportion of women trainees. However, we have found in a survey of general practices in Oxfordshire that women are still under-represented as general practitioner principals and that some women patients are seeking women doctors without success. We suggest that neither ability nor training is the problem and that there may be important difficulties for women arising from attitudes to women doctors and lack of opportunities for part-time work in general practice.

Introduction

THE impression has been growing that it is more difficult for women than for men to find career posts in general practice, and that part-time work is particularly difficult to find. At the same time there has been an increasing number of women in medical school. The Sex Discrimination Act and the Equal Opportunities Commission have led to greater public awareness of the need to confront the difficulties facing women and an increasing number of articles in the medical journals has attempted to deal with this problem.

Aim

Many women doctors who want a responsible career post look to general practice and we wished to find out first, what problems they may encounter and secondly, the ease with which patients, particularly students, may choose the sex of their doctor.

Method

The success of women doctors in finding posts relative to men cannot be studied directly, as no data have been collected on applications for partnerships. We have therefore had to use indirect evidence and we have looked at the proportions of male and female general practitioners in Oxford from this point of view.

We tried to assess the ease of access of patients to women doctors from the distribution of women general practitioners in Oxford.

Results

Training facilities for women

Nationally the proportion of women entering medical school has risen in the last 10 years (University Grants Committee, 1968 to 1977) from 24·2 per cent to 35·4 per cent, and is projected to reach 40 to 50 per cent in future. The figures produced by the Universities Central Council on Admissions (1968 to 1977) for the same period, though not precise, suggest an increasing number of women applying (27 per cent to 35 per cent) with a slight relative increase in their success rate. In 1968, successful applications of women and men were equal at 46 per cent, while in 1977 39 per cent of women and 36 per cent of men obtained places in medical school.

Among full-time vocational general practitioner trainees currently on a scheme in Oxford, seven out of 20 were women and this is in line with the Regional figures (1972 to 1978) when 44 women and 78 men completed full-time vocational training in the Region.

In the Oxford Region part-time postgraduate training has been well established since 1967 with the introduction of a part-time training scheme which has attempted to provide, in a setting of realistic working hours and conditions, postgraduate training with a view to career posts for women in hospitals and general

practice. No figures are available for the whole Region but in the Oxford Area at least 12 women are training for general practice on a part-time basis. We estimate that in the Oxford Family Practitioner Committee area this represents a total of five to seven women each year who have undertaken local training and are ready to enter general practice full or part time.

Proportion of general practice posts held by women

The proportion of general practitioners who are women in England was 15 per cent in 1976 (DHSS, 1978). The Oxfordshire Family Practitioner Committee has responsibility for 236 principals and salaried partners (Table 1), of whom 203 are men and 33 are women (14 per cent). There are 31 women working full time and only two have part-time posts. We recognize that some full-time posts may involve working only 20 hours plus on-call hours but these are informal arrangements which are not recorded officially.

Of the 33 women, nine are in practice with their husbands or fathers. In addition, six women work as assistants, five part time and one full time (Table 2). There has been no change in this area in the proportion of women general practitioners in the last four years, with an average general practitioner turnover of 14 per year (Oxfordshire Family Practitioner Committee, 1978).

Unemployment among women doctors

There are no official figures on unemployment among women doctors in this area. However, the problem for those seeking general practice positions has been indicated by Hasler (personal communication). His survey of 40 women and 40 men completing the general practice year between 1976 and 1978 showed that six women but no men were involuntarily unemployed.

Patients' attitudes and access to women general practitioners

There has been much controversy but few facts about the preferences of some patients for a woman doctor. The best information we could find is in a survey, not yet published, by Cartwright (personal communication). This confirmed the general impression that while most patients (75 per cent of men and women) expressed no preference for a doctor of either sex, there

Table 1. Career posts in general practice in Oxfordshire.

Date	Principals		Salaried partners		Assistants		
	Men	Women	Men	Women	Men	Women Full-time	Women Part-time
1 January 1975	204	31	3	1	0	0	4
1 January 1976	204	33	1	1	0	1	4
1 January 1977	202	31	1	0	0	0	6
1 January 1978	201	33	2	0	0	1	5

Source: Oxfordshire Family Practitioner Committee.

Table 2. Women general practitioners in Oxfordshire at May 1978.

Full-time principal	31
Part-time principal	2
Salaried partner	0
Full-time assistant	1
Part-time assistant	5

Source: Oxfordshire Family Practitioner Committee.

Table 3. Distribution of women general practitioners in Oxfordshire according to size of practice.

Women doctors in each practice (principals and assistants)	Principals in each practice 1	2	3	4	5+	Total practices
0	17	5	10	11	3	46
1	1	6	4	5	7	23
2	0	1	3	2	2	8
Total practices	18	12	17	18	12	77

Source: Oxfordshire Family Practitioner Committee (1978). Medical list.

Table 4. Distribution of male and female general practitioners in urban areas of Oxfordshire FPC.

Town (over 10,000 population)	Private household population (1978 estimate)	Men general practitioners	Women general practitioners
Abingdon	21,362	13	1 part-time
Banbury	34,945	19	2 (1 full-time, 1 part-time assistant)
Bicester	14,784	9	1 part-time assistant
Carterton	11,769	6	0
Didcot	14,664	9	0 (1 left April 1978)
Henley	11,191	8	0
Kidlington	10,547	5	1
Oxford (plus Botley)	90,686	61	16 (1 part-time assistant)
Witney	13,326	7	2 (1 part-time assistant)

Sources: Oxfordshire Family Practitioner Committee (1978). Medical list.
Oxford County Council.

Figures given refer to general practitioners with surgeries in the town, not exclusively those whose main practices are there.

Table 5. General practices in Oxfordshire undertaking college doctor functions.

	University of Oxford undergraduate colleges		
Practices	Mixed 1979	All male after 1979	All female after 1979
Three practices with a woman general practitioner	9	3	2
Four practices with no woman general practitioner	13	0	1

was a substantial minority of women (21 per cent of women questioned) who wished to see a woman doctor. A similar proportion of men wished to see a male doctor. Only three per cent of women actually preferred a male doctor. We looked to see how many practices in this area offer a choice of a woman doctor to those who wish it (Table 3).

There are 77 practices of which 46 (60 per cent) have no woman practitioner, either as principal or assistant. Twenty-three have one woman, eight have two. Only half of group practices (three or more practitioners) have a woman doctor.

Some areas are worse than others from this point of view. Table 4 gives the figures for towns with populations over 10,000. In particular, Didcot, Henley, and Carterton have no woman general practitioner according to the Medical List for May 1978 (Table 4).

Abingdon has one woman general practitioner, a part-time principal, in a population of 21,362, Banbury has two assistants, and Bicester a part-time assistant only. Oxford city (plus Botley) has relatively more women doctors but even here over half the practices have no women in practice (15 of 29 practices).

Student population

Oxford is a university city with no student health service. Colleges arrange for general practitioners to take their students on to their lists, and these doctors form a College Doctors Association. All these college doctors (13 in seven practices) are men although half of them are in practices which include a woman. There are many women students and the proportion has recently increased as most colleges became co-residential in October 1979. Oxford Polytechnic and Westminster Teacher Training College, with a high proportion of women students, are registered with all-male practices (Table 5).

Discussion

Despite the increase in women medical students to over a third, the proportion in general practice lags far behind, increasing from nine per cent in 1963 to 15 per cent in 1976 (we have no figures for 1978). This study in Oxfordshire is instructive in finding out why this should be so. Over the past six years women have made up one third of doctors completing the general practitioner vocational training scheme in this Region, and in addition there are many women training part time so the proportion may approach 50 per cent. Yet the proportion of women in general practice at 14 per cent in May 1978 is no higher than the national average for 1976. Such figures and Hasler's evidence of unemployment demonstrate that, in this area at least, the relative lack of women general practitioners is not due to a shortage of trained women doctors. The reasons must lie elsewhere, perhaps in the attitudes of the profession. Women working full time seem to have less chance of finding a partnership than their male colleagues.

Even more striking is the lack of part-time jobs in an area where part-time training is so well established and this could be a big factor preventing some women from entering general practice. Most women doctors will marry and have children which may involve at least a proportion of their career being in part-time work. A range of jobs is needed from clinical assistantships involving two to three sessions per week to partnerships involving a heavier commitment. Compared with a few years ago in Oxford, women are favouring four to six sessions rather than two to three sessions in training posts which involve continuing responsibility for patients (Rue, personal communication).

As general practice vocational training becomes compulsory there will need to be real flexibility to allow women to train to the required standard and this flexibility will need to extend to careers if women's skills in general practice are not to be wasted.

The Universities Central Council on Admissions provides figures which are based on candidates by first choice of medical school compared with total acceptances. While not directly correlated they suggest that within the medical schools women have equal opportunities, though cultural influences of home and school may be reflected in the lower numbers of women applicants. If the barriers to women entering medicine have been lowered in the medical schools and in some aspects of postgraduate training, this cannot be said of general practice, at least in this area.

This situation is not only discouraging for women doctors: patients, also, we feel, should be able to have a choice of a woman general practitioner or between women general practitioners (as they can among the more numerous male general practitioners). Our figures show not only small numbers of women general practitioners but also that they are distributed in such a way that in some areas a patient would find it difficult to register with a woman doctor. The sex of the doctor is not usually the main factor determining the patient's choice of his or her general practitioner, but there are situations in which this may become important and this is reflected in the minority who would prefer to have a

woman doctor. For example, some older and younger women are hesitant about bringing certain problems to a male doctor, and often this is revealed only when a previously all-male practice takes on a female trainee or partner. Anecdotal evidence of this comes also from family planning, child health, cytology, and menopausal clinics when a patient meets a woman doctor for the first time. It would be interesting to know from the limited number of surveys done whether women expressing no preference had had previous experience of a woman doctor, as it is at least possible that this may affect their attitude.

The attitude among women students at this university does seem to be clear. A major complaint from women in some mixed colleges has been the lack of choice between a man or a woman as their doctor. In a recent report by the Oxford University Student Union Co-residents Committee (1978) it was strongly recommended that mixed colleges should have both male and female doctors. As more colleges in Oxford become co-residential the shortage of women general practitioners will be felt as more of a problem. Students are in Oxford only for part of the year and, although this is not compulsory, find it easiest to register with the college doctor.

From our figures in Oxfordshire there is no evidence yet that the general practitioners are adapting in order to provide adequate part-time career posts. While there is evidence that training and ability are not the problem, the reasons for this lack of adaptation have to be sought. These might be concerned with attitudes to women in careers, to the possibility of part-time work in general practice, and/or with the structure and financing of general practice.

In a recent survey Savage and Wilson (1977) pointed to a lack of a positive attitude within the profession towards women in medicine. There has, however, been a change within the profession towards accepting the fact that good organization allows for continuity of care with reasonable working hours, and an increasing number of general practitioners now take time out of the practice for teaching, clinical assistantships, and other posts. We hope that as a result of this change and the recognition of the need to use the resource that well trained women doctors represent, attitudes may become more positive. The combination of a part-time career with the bringing up of a family should be no longer regarded as a second-rate occupation or associated with lack of commitment.

As well as a change of attitude, the structure and financing of general practice may need to be re-examined in order to provide a pattern of career posts for women in general practice which meet the varied needs both of doctors and their patients.

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Addendum

Since this article was written in July 1978, some more women doctors have become partners in Oxfordshire. We hope to monitor and report the trend in the future.