

Gender differences in general practitioners at work

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SUMMARY

Background. The proportion of female general practitioners is steadily increasing.

Aim. To compare male and female general practitioners with respect to their job satisfaction and professional commitments within and outside their practices.

Method. A questionnaire was sent to all 896 general practitioner principals with patients in Staffordshire in 1994. The main elements were: job satisfaction (on a five-point scale) from eight possible sources; whether personal responsibility was taken for 12 different practice tasks; and professional commitments outside the practice.

Results. A total of 620 (69%) general practitioners responded. Female doctors derived more satisfaction than male doctors from relationships with patients ($P = 0.002$). Female doctors were more likely to be working in training practices, and were likely to be on-call less and to work fewer sessions. Male general practitioners were more likely to take lead responsibility for practice computers, minor surgery, meeting external visitors and finance, whereas female practitioners were more likely to be responsible for looking after women patients' health.

Conclusion. Considerable differences were found between male and female general practitioners. These differences are likely to have an increasing impact as the percentage of female general practitioners continues to rise.

Keywords: general practitioners; job satisfaction; gender differences; work.

Introduction

THE proportion of female medical students in the United Kingdom has risen steadily over the last 20 years so that medical school intakes now comprise similar numbers of men and women. Over half of all general practitioner (GP) registrars (trainees) are now female,¹ and the proportion of female GPs has increased from 19% in 1983 to 29% in 1993.

With the increasing numbers of female GPs, any gender differences between male and female GPs will become more important. These gender differences may include differences in career progression, job satisfaction, clinical and professional interests, mental health, assumptions of family responsibilities, extent of part-time working, and consulting styles.

Studies following up doctors who have completed their vocational training for general practice have found that nearly all doctors of both genders continue to work,² but that women are less likely to become principals than men³ and are much more likely to be working as part-time principals.² These differences in the career progression of men and women doctors have been

ascribed to gender-based stereotyping, to role strain and its impact on relationships, and to the lack of role models for women.^{4,5}

Women GPs have been found to have greater overall job satisfaction than male GPs or to the general population.⁶⁻⁹ Women GPs have been found to be more satisfied than their male colleagues with their hours of work,^{7,8} recognition for good work,^{7,8} freedom to choose methods of working^{7,8} and psychosocial aspects of care,⁹ whereas male GPs tend to be more satisfied with the organizational aspects of their work.⁹ Lower rates of job satisfaction are important not only from the point of view of the individual doctor, but also because of the association with mental and physical ill-health and increased sick leave.¹⁰

Little work has been published about the influence of gender on the division of practice work between GP partners, but male GPs attending educational meetings have been found to elect for service management topics, whereas women are more likely to select health promotion meetings.¹¹ Considerably fewer female than male GPs seem to be involved in teaching or training.³

This paper presents differences between male and female GPs in their practices, in sources of satisfaction at work, in professional commitments outside their practices, and in responsibilities for practice tasks.

Method

In June 1994, all 896 GP principals with patients in Staffordshire were sent a questionnaire. This included questions about the number of partners, the training status of the practice, the level of seniority, the number of half-days free of practice or medical commitments and the frequency of on-call duty. Enquiry was made about work done outside the practice and about participation in any professional committee(s). Subjects were asked to indicate who (if anyone) had special responsibility in their practice for a total of 12 activities, all of which would be expected to be carried out in every practice. Finally, eight questions about GPs' sources of satisfaction at work were derived from group discussions and the background literature.^{9,10} Two discussion groups, one with eight women GPs and the second with 10 doctors of both genders, were held, the topic set being GPs' stress and job satisfaction. Eight possible sources of satisfaction were identified, and for each of these, subjects were invited to respond on a five-point Likert scale, ranging from 'no' satisfaction to 'extreme' satisfaction (scale 0-4).

Questionnaires were despatched to individual practitioners via the family health services authority (FHSA) courier system and completed forms were returned in freepost envelopes. Detachable code numbers were appended to the questionnaires to allow chasing of non-respondents, who were reminded twice.

Staffordshire FHSA was the responsible authority for 502 of the GPs. The other 394 GPs included in the survey had some patients residing in Staffordshire, but most of their patients lived in neighbouring counties and their responsible FHSA was one of the nine others neighbouring Staffordshire.

A Minitab package was used to process the responses. Tables of unordered categorical data were analysed by the chi-squared test. The Mann-Whitney test was used for ordered categorical data¹² when two groups were being compared; the Kruskal-Wallis test was used when three or more groups were

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being compared; these tests included an allowance for ties. The *P*-values calculated for these last two tests were two-sided. Cochran's technique¹³ was used to investigate whether some of the gender differences that were found were caused by confounding factors causing a spurious association.

Results

A total of 628 questionnaires were returned, of which eight were mainly incomplete and so were discarded, leaving 620 for analysis (final response rate = 69%). Four hundred and eighty-one out of the 620 respondents were male (78%). Significantly more women than men responded (77% women versus 67% men, $\chi^2 = 6.1$, $P = 0.01$). The mean age of respondents was less than that of non-respondents (43.6 versus 47.6 years, respectively, $t = 6.08$, $P < 0.0001$ by unpaired *t*-test).

Practice characteristics

Twenty-six respondents (4%) were in all-female practices, 231 (37%) were in all-male practices and 363 (59%) were in multi-partner practices with at least one female and at least one male doctor. Seventy-seven (12%) respondents were single-handed practitioners.

Table 1 shows the number of partners, level of seniority, and time at work of the male and female GP subjects. Female doctors were significantly more likely than men to work in a training practice ($\chi^2 = 8.28$, d.f. = 2, $P = 0.02$) and as likely to be trainers themselves (overall 29.1% men and 37.5% of women worked in a training practice). Male doctors tended to be more senior than their female colleagues ($P < 0.0001$, by Mann-Whitney *U* test). Women practitioners tended to be on-call less often ($\chi^2 = 81.70$, d.f. = 3, $P < 0.0001$) and work fewer sessions in the practice ($\chi^2 = 104.38$, d.f. = 3, $P < 0.0001$) (see Table 1). No gender differences were found in the proportions of male and female practitioners working in the different categories of fundholding practices.

Cochran's technique was used to determine whether the finding of women being more likely to work in a training practice could have been a spurious association caused by female doctors being younger, and younger doctors being more likely to work in a training practice, but even after allowing for the difference in age distribution, female doctors remained more likely to work in a training practice ($P = 0.04$). When Cochran's technique was used to allow for the differences between male and females in age and number of sessions worked per week, the difference in seniority between male and females was considerably smaller, and no longer significant at $P < 5\%$, and so the difference in seniority does appear to be a spurious association. The gender differences in frequency of on-call duties were too large to be accounted for by females being younger or more likely to work part-time.

Commitments outside the practice

Seventy-one per cent of men and 75% of women doctors did not belong to any committee. Males were more likely than females to represent GPs' views on medical politics committees such as the local medical committee (15% men versus 7% women) and the sexes were equally represented on educational committees (7% men versus 6% women). Male doctors were more likely to hold a post outside the practice than women doctors (48% men versus 38% women, $\chi^2 = 8.39$, $P = 0.005$). The most common type of post outside the practice was doing hospital/clinical work (32% men versus 23% women).

Job satisfaction

Table 2 shows the mean satisfaction scores that male and female

Table 1. Practice characteristics of male and female general practitioners.

Practice characteristics:	Percentage of general practitioners	
	Male (n = 481)	Female (n = 139)
Number of partners:		
single-handed	13	9
2 - 3	26	32
≥ 4	60	58
no response	0	1
Level of seniority		
single-handed	13	9
most senior	28	16
2nd	24	22
3rd	15	14
≥ 4th	16	34
all equal	1	4
no response	2	1
On-call frequency (days per month):		
never	2	17
≤ 4	12	27
5 - 8	55	28
≥ 9	28	21
no response	3	7
Half-days free from practice work:		
none	18	10
1,2	74	51
3,4	2	25
≥ 5	1	7
not known	5	6

Table 2. Comparison of male and female general practitioners' mean scores for satisfaction levels at work.

Aspect of satisfaction	Mean satisfaction score (range of answers 0 - 4*)	
	Male (n = 481)	Female (n = 139)
Relationship with patients	2.9	3.2†
Ability to treat illness	2.9	3.0
Relationship with practice staff	2.7	2.8
Relationship with other doctors	2.6	2.7
Financial security	2.6	2.6
Public view of profession	1.6	1.6
Own working conditions	2.3	2.3
Prevent illness by health promotion	1.3	1.4

*0 = not a source of satisfaction, ranging to 4 = extreme source of satisfaction.

† $P = 0.002$, Mann-Whitney test.

N.B. Non-response varied between 2 and 5% between questions.

GPs gave to the eight possible sources of satisfaction. Women doctors derived significantly more satisfaction than men doctors from relationships with patients ($P = 0.002$, by Mann-Whitney *U* test). No other gender differences were found.

Responsibility for practice tasks

Responses from practices with at least one female and one male

partner are described in Table 3, in which individual respondents' own involvement in taking responsibility for practice tasks is reported.

Women were significantly more likely than men to be responsible for women patients' health and antenatal work. Male doctors were significantly more likely than their female colleagues to be responsible for practice computers, minor surgery, meeting external visitors, writing the annual report and practice finance.

Responsibility for child care

There were large differences between those male and female respondents with children under 10 years of age as to who cared for the children if they were sick ($\chi^2 = 113.9$, d.f. = 5, $P < 0.0001$): 66% of male doctors with children of this age group reported that their partner or spouse would look after a sick child, whereas this was the case for only 2% of women with young children. Seventy-five per cent of women with children under age 10 arranged for somebody other than themselves or spouse/partner to care for a sick child, whereas this was the arrangement for only 16% of male doctors.

Discussion

It seems reasonable to generalize from the results of the research reported here to GPs across England and Wales as the age and sex distribution of the Staffordshire doctors is similar to figures for all GPs in England and Wales.¹ As with any study such as this, it is difficult to estimate the effect of the non-responders (here 31%) on the observed results; all that is known about the non-responders is that they tended to be slightly older and were more likely to be male.

Women practitioners were more likely to work in a training practice than men (even when allowing for the women being generally younger), which could have arisen from training practices positively discriminating in favour of women when appointing a new partner as a result of patient pressure for a choice of gender. Women tended to be on call less often and worked fewer sessions in the practice than men. This is probably related to their greater

Table 3. Percentage of male and female general practitioners who report that they themselves have lead responsibility for particular practice tasks in practices where there are partners of both genders ($n = 363$).

Task	Percentage of general practitioners claiming personal responsibility		P *
	Male (n = 250)	Female (n = 113)	
Computers	22	3	<0.0001
Minor surgery	24	8	0.0005
Practice finance	20	9	0.01
Practice administration	12	5	0.09
Women's health	1	31	<0.0001
Staff employment	10	4	0.07
Staff personal problems	12	16	0.5
Antenatal work	4	16	0.0005
Meeting external visitors	16	2	0.0002
Annual report	18	7	0.01
Health promotion	16	9	0.1
Buying equipment/stores	10	5	0.2

*P-value by χ^2 test.

responsibility for child care, which was found in this survey.

In the 1980s, women doctors were found to be less likely than men to play a full part in medical politics, sit as representatives on committees or hold key positions of power.^{14,15} In this survey, women were nearly as likely as men to belong to a committee, but they were not yet as involved in medical politics.

Women doctors derived more job satisfaction than men from their relationships with patients. This ties in with research from Australia,¹⁶ where a survey of 500 GPs found that women were more likely to be orientated to relationships with patients than men, as well as being better able to identify and treat patients' psychosocial problems. But the largest differences in the survey were in the responsibilities for practice tasks. Women were more likely than men to be responsible for women patients' health and antenatal work, whereas men were more likely to be responsible for practice computers, minor surgery and several administrative tasks. It is difficult to determine to what extent these gender differences have arisen from personal aptitudes and preferences, or from confinement in traditional roles. The former would seem to be more acceptable than the latter. Howie *et al*¹⁷ have demonstrated that GPs who are forced to deviate from their preferred styles at work are more likely to underperform and feel stressed.

All doctors of both genders should be given opportunities to develop as individuals, so that diversity is encouraged and the strengths of all doctors of both genders are fully exploited.

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