PRACTICE OBSERVED

Practice Research

Screening for schistosomiasis among the Yemeni population in Eccles

P L GANVIR, J M V PACKER, R H MALLARD

Abstract

A population of Yemenis living in the north of England was screened for schistosomiasis. Schistosome ova were found in the urine of five of the 104 patients who were screened, but only two received treatment, owing mainly to the mobility of the population. The results of the screening programme showed that it is possible to obtain the enthusiastic cooperation of many individuals, and organisations, most of whom do not normally work together as a team.

Introduction

Although it has been estimated that roughly 200 million people in various parts of the world are infected with schistosomiasis,¹ it is unusual for a general practitioner in the United Kingdom to encounter many cases in his practice. One of us (PLG) has a community of Yemenis in his practice, and 22 cases of the disease occurred among them between 1969 and 1982.

The first patient presented with symptoms of ureteric colic. A radiograph of the abdomen showed calcification of the urinary bladder, and a genitourinary surgeon established a diagnosis

of schistosomiasis. After this Yemeni patients who complained of urinary symptoms were investigated for schistosomiasis, and several cases were diagnosed and treated over the next few years. Because the evidence indicated an appreciable incidence of the disease a screening programme was begun.

In 1980 the general practitioner and a community physician decided to form a team, which included staff of the local authority environmental health department and of the public health laboratory, to carry out a screening programme of the Yemeni population by examining specimens of urine and faeces for schistosome ova, starting with the men employed at a local factory.

Methods and results

Urine, which had been collected from each person during a four hour period in the middle of the day, was filtered through a Whatman 541 filter paper and then stained with a freshly made saturated aqueous solution of ninhydrin (BDH 44060), dried at 42°C, and examined for the presence of purple stained schistosome ova. Specimens of faeces were examined for helminth ova by direct microscopy and microscopy after formal-ether concentration.² Salmonella and shigella were sought by standard culture methods. At least one urine and one faeces sample were submitted by 104 persons. Schistosome ova were seen in the urine of five of the men, none were seen in the faeces samples (table). No ova were detected in the samples of urine or faeces from the women. Three of the five men had in the past been investigated for urinary symptoms. One had had schistosomiasis of the bladder, which was confirmed by biopsy, but the ova had appeared degenerate so no treatment had been given.

As a result of the screening two of the men were treated with niridazole 500 mg three times a day for seven days. No ova were found in a subsequent urine specimen from one man. The other was investigated for complications of a bladder. A bladder biopsy showed degenerative ova only. Two of the remaining three men returned to the Yemen before receiving treatment, and we tried unsuccessfully to contact the third man. Samples of faeces from the two obtained during the screening programme yielded the

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752
Results of screening for schistosomiasis, analysed by age and sex

Age (years)	Males		Females	
	No. of Yemenis in the practice population	No. screened	No. of Yemenis in the practice population	No. screened
0-14	17	4	14	4
15-24	21	0	17	0
25-34	20	0	15	0
35-44	26	1	10	0
45-54	14	0	11	0
55-64	15	0	10	0
65+	15	0	10	0
Total	127	97	94	7

* Schistosoma haematobium found. Schistosoma sp. not identified.

following incidental findings. *Shigella flexneri* in a man aged 60, infertile ascari ova in a man aged 56, ova of *Trichuris trichiura* in a man aged 54, and ova of *Hymenolepis nana* in a man aged 37.

Discussion

General practice is becoming orientated more and more towards preventing disease rather than solely offering treatment to patients after disease has become established. Among the Yemeni population that we surveyed schistosomiasis was causing noticeable morbidity, and in most cases the disease was at a late stage by the time the patients consulted their general practitioner with symptoms. Thus irreversible damage had been caused in some to the urinary tract or to other viscera. An association between schistosomiasis and cancer of the bladder has been reported.³ Primary prevention was not appropriate because the infection is acquired in the Yemen. The disease is not endemic and is not spread in Britain because the intermediate hosts (snails of genus *Bulinus*) are not present. Direct person to person spread does not occur. Immunity does not follow initial infection, hence repeated infections commonly occur in people in endemic areas. We concluded that early detection of the infection by screening should be attempted.

We considered the yield of 5% of cases of schistosomiasis to be a worthwhile outcome of the screening programme. It was, however, disappointing that only two of the five cases discovered received treatment. This was in part due to the mobility of the population—Yemenis frequently move within the district in which they live in Britain, and they also spend time in the Yemen. Language was another obstacle. We plan to continue the screening programme by testing a sample of urine and faeces when an individual first consults the general practitioner after arriving in or returning to Britain from the Yemen.

We thank Dr R L Marcus, occupational health physician, Pilkington's Tiles Ltd and Mr K Rowlands-Price, environmental health manager, Salford City Council, and their staff for help in carrying out this programme, and Mrs W. Bailey, Liverpool School of Tropical Medicine and Hygiene, for advice and for demonstrating the filtration technique.

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100 YEARS AGO

The Convocation of the University of London met on Tuesday last, and again passed a resolution urging upon the Senate the desirability of holding the Prætorian Lecture, Mr B. Examination twice a year. The resolution was, as usual, carried by an overwhelming majority. In a house of nearly a hundred and thirty, there were but two dissentients. It might be thought that the Senate would be ready, even eager, to give effect to the opinion thus emphatically expressed by a body which includes so many men fully qualified to represent every department of teaching. Unfortunately, past experience does not warrant such a hope. The same recommendation made in former years, has been met by the Senate in an uncompromising spirit. That oligarchic body, confident of the infallibility of its educational theories, has not only rejected the advice of Convocation, but has even tightened the regulations which that body decided to be too tight.

If this be a fair index of the temper of the Senate, what hope is there that it will listen to any recommendation which may be made by the special committee which Mr Anstie, Q.C., obtained, to consider the proposals lately published by the Association for Promoting the Establishment of a Teaching University for London? We are far to hope against hope that the Senate may at length be brought to recognise the strength and depth of the movement. Dr Robert Barnes said that if the University could not find under the changed conditions produced by the advance of the higher education, a *modus vivendi*, it would soon find it necessary to contrive a *modus moriendi*. There are some signs that the University may not thus commit suicide. Nine members of the Senate have joined Lord Reid's Committee, and Mr Richard Hodi Hutton, the only member of the Senate who spoke on Tuesday, though he committed himself in making light of the importance of the present movement, admitted that a closer connection between

teaching and examination was very urgently needed. This is not a large admission; still, it is something to find even one member of that embosomed body recognising the necessity for reform. There are indications that other members of the Senate are beginning to perceive this obvious truth. Objections which are grounded merely on the imperfections of the draft scheme submitted last month to Lord Reid's Committee will not advance the question. The scheme was profoundly practical, tentative, and, so far from being designed to settle the question, was, in reality, intended to open it up, and afford a ground for discussion. Convocation, at least, would appear to be fully impressed with the importance of the crisis which has arisen. Mr Anstie's motion was carried unanimously, and the committee appointed comprises many men of the first rank. It was, perhaps, unfortunate, that it was necessary to nominate the members of the committee on the spot of the moment, but, even with this disadvantage, it was not difficult to obtain a list of names which must command the respect, and it may be hoped, also the attention of the Senate. We shall not attempt to forecast the tenor of the report of this important Committee, but as that body contains several of the most active members of Lord Reid's Committee, the necessity for reform will certainly be fully discussed by it. The needs of the great medical school of London, and the general opinion of the medical profession, have long ago found expression, and now the demand of the teachers of all faculties has been distinctly formulated. This demand cannot be ignored. Will the University of London, which has for so many years proudly in the van of progress, make itself the champion of a movement, which is the result of the legitimate aspirations of the great teaching institutions of London, of its numerous colleges and medical schools, whose students are drawn from all parts of the kingdom? *British Medical Journal* 1985; **94**.

Women doctors in urban general practice: the patients

M COOKE, C RONALDS

Abstract

A large study from a representative sample of general practitioners in Manchester showed that women doctors saw more women patients than men doctors, especially the childbearing age group. They saw a similar range of diagnoses as men doctors, though they saw more women patients for cervical smears, contraception, and breast disorders. Preventive health care may not be adequately provided for these in practices without a woman partner.

Introduction

It has been suggested recently that the role of women doctors in general practice should be documented.¹ An editorial in the *Journal of the Royal College of General Practitioners* suggested the need for evidence of "not the disadvantages but the advantages that women have in general practice."² Although men are not asked to provide evidence of their "special role," there is a lack of data about the work that women general practitioners do.

Over the past few years patients' rights and women's places to see a woman doctor have been recognised.³ Since only 18% of principals in Britain are women many women are limited in exercising their rights to choose a doctor. Many of the opinions about the preferences of women patients and the role of women doctors in general practice need to be tested against objective evidence. To compare the work of women and men general practitioners we used some of the data available from the large scale Department of Health and Social Security study of Manchester general practitioners, that was carried out in 1981. We look first at the characteristics of the patients seen and their patterns of morbidity. In the second paper (p 755) we examine the doctors' characteristics, their geographical distribution and workload, and the care provided.

Other studies

Few studies have compared the work of women and men general practitioners. Cartwright and Anderson studied a sample of general practitioners, of whom 13% were women, and found no difference in the attitude and behaviour of the men and women studied.⁴ Two studies compared the consultation patterns of female and male partners in individual practices. Hopkins *et al* noted that the female partner saw twice as many women patients as the male partners and that there was a notable sex difference in the attendance rates for embarrassing conditions, with women opting to see the woman doctor.⁵ Preston-Whyte *et al* showed that in one practice two full time women doctors saw different distributions of patients by age and sex from their full time male partners. They showed that patients chose to consult a doctor of the same sex not only for "sex specific" disorders but also for conditions that were not "sex linked," such as circulatory disorders. The female partners saw more gynaecological disease, gave more advice about contraception, and took more cervical smears. Furthermore, though the women principals followed

up men patients to the same extent as their male colleagues, they had an appreciably higher rate of doctor initiated follow up consultations for their women patients.

Method

The DHSS Urban Primary Care Research Unit in the department of general practice at this university carried out a study of the structure and process of urban care in the Manchester area. The study area was Manchester North, Central, and South and Salford and Trafford health authorities. In May 1981 there were 485 general practitioners with surgeries in the area, of whom 366 (75%) provided structured interviews concerning their personal and practice characteristics.⁶ Of these, a subsample of 183 general practitioners agreed to provide selected data about every patient contact for one day at a time on 20 selected days in the year. To ensure that there was no bias from seasonal variation 15 of these days were selected using an appropriate protocol. Data were recorded on age, sex, occupation

FIG 1—Age and sex of patients consulting by the sex of the doctor

of the head of the household; presenting symptoms, provisional diagnoses, and action taken, including the issue of prescriptions and certificates; the use of laboratory tests or x-ray examinations; referrals to consultants, nurses, and social services; and arrangements for follow-up.⁶ Of the 485 general practitioners in the study area, 183 (91%) were women. Of the doctors completing the questionnaire, 187 (67%) were women. In both studies there was a slight bias towards younger general practitioners, otherwise both female and male respondents were highly representative of the study population for place of qualification, size of partnership, number of patients on list, and type of premises.

Results

All of the information on patient characteristics and morbidity comes from the data on consultations collected by 183 general practitioners.

CHARACTERISTICS OF PATIENTS

Age and sex

The results of most surveys have shown that roughly 60% of patients who consult in general practice are women, and we found a similar proportion. Figure 1 shows the age and sex of the patients

who consulted by the sex of the doctor. Women doctors saw a higher proportion of women patients—roughly 60%—than men doctors, roughly 60%. This contradicts Cartwright and Anderson's findings that female and male principals saw the same proportion of women patients,⁴ but agrees with the findings of other studies.⁵ Table 1 shows the range of percentages of consultations by women by the sex of the doctor. Women doctors who saw high proportions of

TABLE 1—Percentage of female patients seen by men and women doctors

	Of female patients	Of women doctors	Of men doctors
	n = 156	n = 27	n = 126
60-84	15	—	—
55-59	15	—	—
50-54	15	—	—
45-49	15	—	—
40-44	15	—	—
35-39	15	—	—
30-34	15	—	—
25-29	15	—	—
20-24	15	—	—
15-19	15	—	—
10-14	15	—	—
5-9	15	—	—
0-4	15	—	—
Range	60-84	60-84	71-85
Mean	66.2	66.2	66.5

women patients (around 85%) were, with one exception, the only women in a practice, and two of them were the only women in group practices of six and seven doctors. Two Asian women doctors who practised in an area with a large Asian population also had high proportions of women patients.

The general belief that women doctors see more children is not borne out by the data. Men doctors see slightly more of the elderly patients, particularly men, which probably reflects the fact that the population of men general practitioners is slightly older than that of the women.

As expected, women doctors see more women in the age group 15 to 34, supporting the view that a certain proportion of women of childbearing age deliberately choose to consult a woman doctor. The preference of women patients for a woman doctor is confirmed by the fact that men doctors in mixed sex practices saw fewer patients with problems associated with the female gender than men in practices with only men doctors.

Social class

There was no difference in the distribution of patients by social class who saw the women and men doctors in the men deprived areas. There was a slight variation only in the more affluent areas, where women doctors saw more working class patients.

MORBIDITY

Figure 2 shows the morbidity patterns in patients seen by women and men general practitioners. There was little difference in these patterns, though the women general practitioners saw more patients with problems in the genitourinary and supplementary categories.⁶ (The latter includes family planning and cervical smears.) Overall, gynaecological, prenatal and postnatal care, family planning, and

cervical smears comprised 13.7% of the morbidity seen by women doctors compared with 8.3% seen by men. There was a single compensatory diagnostic group seen by men doctors but a slight excess distributed over a wide range of categories.

FIG 2—Pattern of morbidity seen in patients according to sex of doctor. The supplementary category includes preventive medicine, administrative, family planning, and social problems.

Table 11 shows that the three conditions for which women patients most commonly choose a woman general practitioner to consult are cervical smears, contraceptive advice other than the pill, and breast disorders. It seems to be important that these three conditions require a physical examination by the doctor, and two are connected with cancer, breast lumps in particular causing great anxiety for many women. Although women patients tend to consult women doctors for all major gynaecological problems, perhaps where the patients perceive that there is a likelihood of a physical examination they are more likely to want to consult a woman.

After excluding categories that accounted for under 0.1% of all consultations (fewer than 100 consultations) and those where

TABLE 11—Percentage of consultations with men and women doctors for gender associated conditions

Category	Royal College of General Practitioners code	No. of cases	Seen by women doctors	Seen by men doctors
Cervical smear	329	329	321	64.9
Contraception other than oral	515, 535-6, 536-9	366	265	72.5
Genitourinary	205-6	320	220	68.8
Breast disorders including neoplasms—for example, vaginosis, candidiasis	022, 044, 091, 287-291, 296	1221	786	64.4
Menstrual trouble	155	155	108	69.7
Cervix and urinary infection	274	1021	689	67.5
Contraception	515	1405	924	65.8
Menopause	291	2538	1675	66.1
Pregnancy, antenatal, postnatal	311, 313-323, 542-544	292	196	67.1
Miscellaneous	292	292	196	67.1
Genital (including neoplasms)	085, 276-284	1045	724	69.3
Ventral disease	022-029	24	4	16.7
All consultations including those not associated with gender		93600	6284	67.2

All consultations including those not associated with gender

differences may have been due to labelling, for conditions not associated with gender women doctors had more consultations for childhood immunisation, iron deficiency anaemia, otitis media, and marital and social problems. Men had more for alcohol problems, dementia, gout, epilepsy, and asthma and carried out more childhood screening and medical examinations for insurance. There seemed to be no difference between women and men in the proportion of anxiety, depression, or stress that they diagnosed. Overall, there was no recognisable pattern to differences in morbidity seen by women and men doctors other than for gender associated conditions.

Discussion

Though the Manchester study was not set up to compare men and women general practitioners, it is one of the few large data bases that provides such information about the doctors and the patients seen by them. When looking at patient morbidity the close similarity in the mix of cases seen by women and men doctors is impressive: the women carry a generalist's workload.

Secondly, the data reinforce all the evidence that patients prefer a doctor of their own sex for gender associated, potentially embarrassing, conditions. Clearly, women doctors have a special role in providing a service for women patients, in particular for cervical smears, contraception, and breast disorders.

Roughly 12 000 women die each year from breast cancer, a further 2000 from cervical cancer, and nearly 129 000 undergo pregnancy terminations.¹² Preventive health care and the early detection of disease are of paramount importance in these conditions. Our data show that women general practitioners do a much greater proportion of this work than men. Lack of access to a woman general practitioner may be a real barrier

to preventive health care for some women; in Manchester only 33% of the practices offered patients the option to consult a woman general practitioner. Thus if there were more women general practitioners available there might be a more effective preventive health service. Although the numbers are small, our data showed that men doctors, too, have a special role in treating men with genital problems.

Women medical students who are considering becoming a general practitioner may be concerned that their work would be primarily in gynaecology and family planning. Since gender associated problems comprised only 13.7% of the morbidity seen by women doctors as a group they cannot be said to be overwhelmed by women's problems.

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Women doctors in urban general practice: the doctors

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Abstract

A large study of general practitioners in Manchester showed that women doctors were younger than men doctors, and few were single handed or worked in deprived inner city areas. They had closely similar patterns of care to their male colleagues, and although they worked slightly fewer hours in surgery, they had almost identical consultation times per patient. Women general practitioners were less active in politics and education than men.

Introduction

Much has been written about the problems of women doctors in obtaining training and employment and of the prejudices

against them.¹ Now that roughly 40% of medical students are women, many of whom may wish to enter general practice, we need more data over to look for objective evidence of whether there are any differences between female and male principals in general practice.

In 1981 the Department of Health and Social Security Urban Primary Care Research Unit carried out a large scale study of general practitioners in Manchester, Salford, and Trafford. We used data from this research for two studies about women doctors in urban general practice. The first paper (753) describes the patients' characteristics and patterns of morbidity seen. From the data on consultations we showed that women doctors have a specific role for women patients, particularly in preventive health, though this is only a small part of their general work.

In this paper we look at the characteristics of women and men doctors and at their geographical distribution, workload, and the care they provide.

Method and results

We used three sets of data in this study: (i) information from the family practitioner committee about 485 general practitioners in the Manchester area; (ii) the results of structured interviews with a subset of 366 general practitioners; and (iii) data on consultations collected

of 183 of these general practitioners the variation was large; therefore we have confined discussion of hours worked to the data actually recorded at the consultation.²

The 183 doctors recorded 74 900 consultations. Women doctors made up 15% (27) of the sample of doctors but saw 13% of the total number of patients who consulted. The mean time spent on each surgery consultation was almost equal for men (7.6 minutes) and women (7.9 minutes). Thus this difference between 15% and 13% reflects the fact that as a group the women were on average providing fewer hours in surgery, though when the mean time spent on each consultation was considered the difference was surprisingly small—13.2 hours a week in surgery for women and 15.0 hours for men. The figure shows the range of weekly surgery consultations by the sex of the doctor. The average number of surgery consultations a week for women

Weekly surgery consultations

doctors was 102 compared with 124 for the men, reflecting the higher proportion of women who provided fewer than 15 hours of surgery time a week and had smaller list sizes.

Of the women doctors who work more than 15 hours in surgery a week, half have registered lists of fewer than 1500 patients compared with 11% of men. Half the men doctors who work fewer than 15 hours in surgery a week have registered lists of more than 2500 patients compared with none of the women. This suggests that some women doctors work longer hours than men, proportionate to their personal list sizes.

When we compared the total time spent in surgery per patient a year, calculated using the average practice list size (total practice population divided by total number of doctors in the practice) the results were 20.4 minutes spent by women doctors and 21.0 minutes spent by men doctors. This implies that even though women work fewer hours a week they give their patients as much time as their male colleagues do and make a contribution to their practice greater than that warranted by the lower numbers of patients on their personal registered lists.

PROCESSES OF CARE

Home visiting rates were closely similar; 11% of women doctors' consultations were in the patient's home compared with 11.7% of the men's. This, however, does not include out of hours calls, which were not recorded. There were no appreciable differences in prescribing rates. Men wrote slightly more certificates for sickness than women. The rates for x-ray examinations, referral, and fax follow up appointments were only slightly lower for women than men. Although men doctors had a slightly higher rate for faxed follow up appointments overall, women patients were more likely than men to get one from doctors of both sexes. Women doctors were slightly more likely to arrange such appointments for women patients.

The only noticeable difference came in rates of requests for laboratory tests: women used tests 3.8% more than men, but for only 4.3% of patients. Controlling for the percentage of women patients in the age group 15 to 44, the difference between rates for women and men general practitioners is extra small. The pattern of requests for tests in the age group 15 to 44 rather than the sex of the doctor accounts for

most of the difference between men and women doctors. The average test rates for women doctors who had more than 25% of patients in that group is 5.6%, and for men doctors 5.3%.

Discussion

Despite almost half the entrants to medical school being women, there is still much prejudice and discrimination against them in the profession.³ Many women face difficulties when trying to acquire postgraduate training and having completed this, even in finding employment.⁴ It is difficult to document the size of this problem in general practice since the women doctors who cannot find training are often isolated, and those who seek work do not complain for fear of jeopardising opportunities for future employment.

The most disadvantaged group are married women with children.⁵ Because of the current definition of social roles it is the woman who usually sacrifices her professional interests for the family.⁶ To counter the disadvantages of marriage and mothering, some women seek part time employment. Arguments as to whether women work less hard, are prepared to be on call, or should work in difficult areas have been used to question their suitability as principals in general practice. Anxieties about these issues may make senior partners, most of whom are men, reluctant to choose a woman partner.

Although nearly a fifth of all general practitioners in the Manchester area were women, only 13% of the practices offered patients the option of consulting a woman doctor since all the practices had shared patient lists. The unequal geographical distribution of doctors was striking, however; in Central Manchester roughly only a fifth of practices offered patients the option to consult a woman.

This relative lack of women doctors in deprived areas is a cause for concern. There is substantial evidence that social groups with higher mortality rates, and thus greater need, make the least use of family planning, maternity, and cervical screening services.⁷ We showed in the first paper (p 755) that women doctors have a special role in providing a service for women patients, or for gender associated, potentially embarrassing, conditions. In particular, their advice is preferentially sought for cervical smears, contraception, and breast disorders.

The present inequalities in health are unacceptable, and one priority for improving them is to increase the effectiveness of the preventive services. Increasing the number of women general practitioners in the deprived inner city areas might help. We do not know whether male principals in inner city areas are unwilling to take on women as partners, fearing they will not share home visiting and out of hours calls or cope with the difficulties of a deprived area, or whether women choose not to work in such areas. It is encouraging that some women doctors are working in one deprived area in Manchester. The evidence is that women do a substantial proportion of home visits and a substantial amount of on call work, though in the inner city areas they tend to use deputising services slightly more than men doctors.

Because the Manchester study was not set up to compare women and men general practitioners, not enough data are available about part time status or marital and family commitments, nor do the quantitative data allow us to make deductions about the quality of care offered by either group of doctors. Furthermore, although the consultation data were recorded for 20 working days from which a structured data base, consisting of the days of three working weeks, was created for each general practitioner, methodological problems prevented us analysing whether women or men doctors have more "days" or "half days" off a week.

The data show, however, that women and men have closely similar patterns of work and provide similar patterns of care. Strikingly, there was no difference in the average duration of consultations. Many women doctors undertake a full time work commitment, and although we cannot compare doctors on a nominally full time or part time status, the data are intriguing.

by 183 of these general practitioners. (See the first paper on page 753 for details of the methods.)

GEOGRAPHICAL DISTRIBUTION OF DOCTORS

More women general practitioners worked in the affluent areas, Manchester North and Central districts, which contain much of the inner city partnership area and local authority and older terraced housing, had a ratio of only one woman doctor to eight men doctors (table 1). Interestingly, the district with the highest proportion of women general practitioners, though a more affluent area, also included one of the largest council estates in Britain, with indices of deprivation equal to those of the inner city. Here the ratio of women to men doctors was 1:1.4 (16 women to 23 men), showing that women are willing to practice in this deprived area.

Although only a fifth of doctors were women, a third of all practices in the area had at least one woman partner (table 1). In all practices with both men and women doctors there were no personal lists and patients could theoretically see the general practitioner of their choice. Among districts, however, from two thirds to a fifth of practices had a woman doctor. In some districts, therefore, especially disadvantaged inner city areas, most women patients have no choice of a woman general practitioner.

SIZE OF PRACTICE AND SEX OF PARTNERS

Few women are in singlehanded practice (table 1). Nearly three quarters of men work with at least one other partner of their own sex, whereas this is so for less than two thirds of women doctors. Just over a third of women are the only female partner in a practice of three or more doctors, whereas this is true for only 0.5% of men.

CHARACTERISTICS OF DOCTORS

More details on the characteristics of doctors were obtained from the questionnaire answered by 366 general practitioners, of whom 67 (18%) were women (table 1). The population of women doctors was younger than that of men, which may reflect the change in policy of admitting more women to medical schools in the past 15 years. Only three women were general practitioner trainees compared with 54 men, and fewer women were members of the Royal College of General Practitioners or took part in professional activities outside their practice. The women with hospital appointments estimated that they spent roughly 6.7 hours at these jobs and the men roughly 7.1 hours. Women spent on average 4.5 hours and men an estimated 5.4 hours a week performing other medical non-hospital work. Women doctors were less likely than their male colleagues to be concerned in internal or child health clinics in the practice but more likely to run family planning and cervical cytology sessions in their practices.

TABLE 1—Characteristics of doctors by sex of doctor

	% of women general practitioners (n = 67)	% of men general practitioners (n = 299)
Age		
Under 35	24	12
35-44	36	28
45-54	30	19
55-64	15	11
Over 65	27	28
Overseas qualified	4	6
Vocational training	4	4
Recognised training scheme	6	2
Self registered	2	0
Trainee	2	0
Postgraduate medical qualification	66	55
Member of Royal College of General Practitioners	16	25
General practitioner trainee	3	1
Officer holder in professional organisation (college, BMA)	1	10
Member of professional or local medical committee, district medical team, health authority	12	28
Have hospital appointment	25	27
Perform medical non-hospital work outside practice	37	54

CHARACTERISTICS OF WORK AND PRACTICE

One criticism of women doctors is that they are unwilling to be on call. Surprisingly, it was found that two thirds of women were on call at weekends and weekdays compared with 91% of men. Almost all doctors used a deputising service after 11 pm. A slightly larger percentage of women doctors used deputising services before 11 pm and at weekends. Women doctors who were on call, however, had slightly more night and weekend duties than their male colleagues. These figures do not take account of part time appointments but show that women do a substantial amount of on call work, though less than men. There was no difference in the number of weeks of holiday taken by women compared with men.

No specific question on full time or part time status was included in the questionnaire answered by the 366 general practitioners. Women general practitioners had smaller personal lists of registered patients than men: just over half said that they had fewer than 1500 patients compared with an eighth of men. This may reflect that more women work part time in their practices, but it may also be due to women doctors who are new to their practices being young.

The doctors were asked to estimate the number of hours a week spent in surgery consultations, which might have indicated part time and full time work, but when the estimated time was compared with the actual time recorded in surgery consultations a week by the subset

The average number of hours a week spent in surgery by all women doctors is only 1.8 hours less than that for all men doctors. Given the actual time worked on the recording days for the group of 183 doctors, 62% of the women and 42% of the men spent fewer than 15 hours a week in surgery consultations.

Our data suggest that there is less difference in the number of surgery hours provided by women and men doctors than might be expected, given that more women than men are thought to be working part time. This raises questions about the meaning of "part time" and whether it is more to do with status and financial reward than the actual number of hours worked in consultations. Do women general practitioners work a similar number of hours to their male colleagues during the day but receive a rather lower proportion of the practice income because they do less night and weekend duty?⁸

Variations in the amount of time spent with patients cannot be explained in terms of the time spent on other professional activities. A similar proportion of women and men undertake hospital work, though more men do other medical work. If flexible practice arrangements can allow a substantial number of principals to have outside commitments, then surely the same flexibility should be used so that more women may be employed in general practice.

Finally, women are underrepresented in medical politics and medical education. There are a little less women trustees in the Manchester area. Role models are an important part of the educa-

tional process, and barriers to the participation of women in training and politics are to be deplored.

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100 YEARS AGO

We have in this journal, for many years, devoted much space and much pains to the purpose of widening the connection of the medical profession with the universities. This word we use in the largest sense. Everything which can bring the students and the members of the profession into immediate relation with the culture of university life, and with the strength and purity of university tests, has our warm sympathy and support. From the first, we have done our utmost to bring constantly under the notice of the profession the immense advantages likely to result from extending university graduation throughout Great Britain, until it should become the rule, instead of the exception. We have done our utmost to foster, to foster, and to facilitate, the progress of the medical movement in Cambridge, and we have done our utmost to foster, to foster, and to facilitate, the progress of the medical movement in London. We have achieved that, at the same time a verification of our earliest predictions, and, in some measure, a result of our continuous support. On the other hand, we have not spared our efforts to bring under the notice of the profession the immense advantages likely to result from extending university graduation throughout Great Britain, until it should become the rule, instead of the exception. We have done our utmost to foster, to foster, and to facilitate, the progress of the medical movement in Cambridge, and we have done our utmost to foster, to foster, and to facilitate, the progress of the medical movement in London. We have achieved that, at the same time a verification of our earliest predictions, and, in some measure, a result of our continuous support. 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