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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(Accepted 22 January 1985)

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 had 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 5.2% more than men. Men made 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 practice is extra small. The pattern of requests for each age group 15 to 44 rather than the sex of the doctor accounts for men

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, in inner city areas they are under-represented. The fact that three 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 willing 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 there are many women doctors working in one deprived area in Manchester. The evidence is that women do a similar 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.

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 PARTNER

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 during their practice. The men 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 doctors (n = 67)	% of men doctors (n = 299)
Age		
Under 35	24	12
35-44	36	28
45-54	30	19
55-64	15	15
Over 65	27	28
Overseas qualified	2	4
Vocational training	4	6
Recognised training scheme	2	2
Self registered	2	2
Trainee	6	15
Postgraduate medical qualification	66	55
Member of Royal College of General Practitioners	16	25
General practitioner trainee	3	1
Office 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 than 10% in the so-called Manchester area. Role models are an important part of the edu-

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

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(Accepted 22 January 1985)

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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