GENDER AND GENERAL PRACTICE

The Single-Handed Woman General Practitioner

by

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Doctor of Philosophy

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April 1987

SUMMARY

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This research examines women GPs' careers, how they run their practices and how they reconcile professional and domestic lives. It looks at the particular experiences of women GPs who practise alone, and at the pressures in past practice experience which have led them to do so. It is argued that many of the problems of group practice which can be identified are attributable to gender. For example, one reason given for entering general practice is a desire to be able to provide the full range of medical care and not to specialise. Women GPs, however, may find themselves seeing more women patients for "women's problems" and children than they would freely choose. Women have not entered general practice in order to specialise in these areas of medicine. Indeed, if they had wanted to specialise in obstetrics, gynaecology or paediatrics they would have had difficulty advancing very far in these male-dominated areas of hospital hierarchy.

Other gender related problems exist for women in general practice and practising single-handedly is one strategy that women GPs have used to counter the problems of working in male-dominated practices and partnerships. However, the twenty-four hour commitment of single-handed practice may bring further pressures in reconciling this with responsibility for home life. Out-of-hours cover, which can be viewed as the link between professional and domestic life, where the one intrudes into the other, is also examined in terms of the gender issues it raises. The interaction of gender and ethnicity is also considered for the 11 Asian women GPs in the study.

Interviews were conducted with 29 single-handed women GPs in the Midlands. In addition, some cases were studied in greater depth by being observed in their surgeries and on home visits for a day each. A qualitative/feminist approach to analysis has been employed.

Women - General Practitioners - Single-handed - Gender - Medicine

ACKNOWLEDGEMENTS

I am grateful to a number of people who have helped and encouraged me at all stages of preparation of this thesis. David Podmore, in particular, has diligently guided my work with both patience and persistence as both supervisor and friend.

Others I should like to mention for their advice, encouragement, friendship and support are Lorna McKee, Judith Farrar and Colin Bell. Paula Kingston of Aston University Library advised and led me through the intricate maze of literature searching. Susanne Lawrence, my sister, has relentlessly borne the brunt of my emotional turmoil in finally producing this thesis. Other friends and colleagues have helped the whole process along.

Gail and Christine have typed the thesis and produced it on a tight schedule - the result of their labours is a work of art.

Finally, I am indebted to the 29 single-handed women general practitioners who gave me their time and their confidences and whose lives form the basis of this thesis.

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CHAPTER ONE

INTRODUCTION: ISSUES OF GENDER

With the plethora of research in recent years on women in the professions both in the UK and the US, knowledge and understanding about the influence of gender within the professions has grown. Medicine, as the epitome of the archetypal male-dominated profession, has in particular been held up for scrutiny because of the way in which women are 'channelled', 'excluded', 'exploited' and 'oppressed' by their male colleagues. The movement of women into a profession which totally excluded them just over a century ago has been well documented, as has the present day exclusivity of the profession's upper echelons (Jefferys and Elliott, 1966; Lopate, 1968, 1971; Lorber, 1975, 1984; Elston, 1977, 1980; Bourne and Wikler, 1978; Leeson and Gray, 1978). Studies have shown medical specialties in which women work in large proportions, and in which they hardly work; in which specialties they reach more senior levels of the hierarchies and in which they do not, with explanations as to how and why they have failed to match their potential. At the same time, analyses of the ways in which women become divided between their professional and domestic roles and the interaction of the two spheres in limiting their options has deepened.

General practice, which has been viewed as one of the specialties which is most suitable for women to enter, has been researched on a number of fronts. Comparative surveys of doctors (and patients) in general practice (Cartwright, 1967; Cartwright and Anderson, 1981); in general practice in health centres and groups (Jefferys and Sachs, 1983) and doctors and nurses

in general practice (Bowling, 1981) are examples of recent large-scale sociological studies of the organisation of general practice. However, such studies have attributed little overall importance to the gender issues involved in primary health care, their focus being elsewhere. Studies of aspects of gender and general practice (Barrett and Roberts, 1978; Gray, 1982; Roberts, 1985) have focussed on the patient and on doctor-patient relationships, while small-scale research has looked at training and careers (Aird and Silver, 1971; Beaumont, 1978) and part-time work (McPherson and Small, 1980). Women general practitioners have given glimpses of their lives in practice and at home (Young, 1981; Everett, 1982). However, very little is known in any depth of women doctors' own perceptions of their experiences in medicine and in general practice, nor of their motives in their choices, decisions and actions, or how the interaction of their professional and domestic lives has conditioned their responses to life events. This study explores these issues, using the women's own perceptions of their situations rather than any measured or 'objective' evidence, as has been the strategy in most other studies.[1] It is particularly important to understand their perceptions, since it is how **they** view their lives that is the basis for their decisions, and their responses to circumstances which determine their actions. In order to set this study in its context, a discussion follows of the 'family doctor' in general practice; the objectives and mode of analysis employed are then briefly considered.

General practice in recent years has come to be viewed as a specialism within medicine. It has evolved out of a type of practice which embodied

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1 See Glaser and Strauss' (1968) comments on 'objective' methods of collecting and analysing data.

the old 'family doctor' ethos. The term 'general practitioner' still evokes images of this traditional general practice, despite significant changes in its organisation. Historically, the GP or family doctor (who was almost invariably male) worked completely alone. In some cases the services of a receptionist were employed, although this position was usually filled by the doctor's wife (Finch, 1983). In fact, with the surgery so often being attached to the GP's home, his professional and home life were inextricably intermingled. Not only was the doctor's wife important to the smooth running of the practice; his whole family were incorporated into and bound up in this demanding 'life' profession, the practice of which was part of life and family. The term 'family doctor', then, was evocative not only of the man who cared for and treated whole families and became a part of his community's family life, but also of a man who brought his whole family into the forefront of this caring role. He was himself the epitome of the good 'family' man, father to his own children and 'father' to his community of patients. His wife, too, was the community's 'mother' and confidante, as well as mother to her children and organiser of both home and (to some extent at least) practice. The doctor's family was the model for family life and his own life was that of the family man in all senses of the word, both professionally and domestically. In the fashion of the good father he altruistically 'sacrificed' himself to his own family and to his professional 'family'.

The concept of the 'family' doctor as depicted in the ideal type above thus had considerable implications for the life of the traditional GP (and for the development of the present general practitioner service). In looking at how the traditional single-handed GP ran his practice, it is clear that the concept of 'organisation' in general practice did not exist as such. The GP

ran morning and evening surgeries for five days a week, plus one on a Saturday, and between surgeries visited patients in their homes - being on call seven days and seven nights a week. This 'total' profession, as it could be called (similar to Goffman's idea of a 'total' institution),[2] generated for many an intolerable pressure - GPs were never able to go home and just shut the door. There was clearly a need for rethinking and reorganising general practice which could both increase efficiency and improve the general practitioner service for the benefit of the doctor, his family and his patients.

Appointment systems were rarely found in traditional general practices (some GPs still prefer not to use them (Cartwright and Anderson, 1981)) and there was a considerable amount of home visiting of patients, a factor which has diminished through the much wider use of cars and telephones and the nature of illness and treatment. There have been other changes, too, which have affected the nature of general practice - such as the creation of the National Health Service, which altered fundamentally the system of remuneration despite GPs retaining their independent contractor status. So, the recent organisation of general practice has been characterised more and more by alternatives to the traditional single-handed GP and 'family' doctor.[3]

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2 Such an occupation or profession is 'greedy' in the excessive demands which it makes on its incumbents. See Coser (1974) for a full discussion of this concept.

3 See Gibson (1982) for an example of the traditional 'family' doctor.

In making gender the central focus of this thesis it is pertinent to give some thought to theories of gender so as to put this study in its appropriate context. Coote and Campbell (1982) have classified gender inequality in simple terms as either radical-feminist or socialist-feminist. Others have developed more complex classifications (Sebastyan, 1979) whilst some have rejected classifications altogether (Stanley and Wise, 1983), and others (Walby, 1986) have attempted to explore the relationship between gender inequality and patriarchy.

These issues have been confronted by feminists extensively. Stacey has suggested that they are still and must continue to be explained. As she has commented:

> There seems to be two sets of problems to be resolved: one is to comprehend the meaning and nature of human service or people work and its implications for the social order in both public and private domains; the second is to understand the way in which the relationships between those domains has changed empirically and is still changing, in particular the way in which the division of labour in the family has been translated to and reinforced in the division of labour in the public domain. (1981: 188)

This thesis seeks to contribute to the understanding of the link between the public and private domains, the 'time-intruding' interface between women's 'public/private' roles as explained below.

The objectives of this study are twofold: on the one hand it seeks to understand and combine the concept of the 'family doctor' depicted above with theories of feminist analysis; on the other it aims to make women visible in a male-dominated profession - medicine - by focussing on their place in one particular specialism - general practice. Single-handed

general practice is chosen as the area of professional practice where the 'public' and 'private' domains interface in the most salient manner.

Pascall defines feminist analysis as:

> about putting women in where they have been left out, about keeping women on the stage rather than relegating them to the wings. (1986: 1)

Women doctors are, overwhelmingly, in "the wings". To overcome the problems they face in their medical careers they use strategies such as retreat into traditional female specialisms and practice, or retreat into traditional female working patterns; alternatively they try to move forward by such strategies as aiming for achievement in traditionally 'male' strongholds or specialisms, or by separating from traditional practice by practising with other women. Little is known about women in medicine who take an apparently anachronistic strategy and choose the more traditional (perhaps outdated) 'male' practice of the ideal-type 'family doctor' portrayed above and epitomized in the single-handed GP. The 'declining species' of the 'sole practitioner' (Podmore, 1979: 356) leads one to surmise that men have left their traditions behind because they have found the 'family doctor' image difficult to fulfil. This thesis focusses on single-handed women GPs, who have chosen to practise as 'family doctors' in the typically 'male' model outlined above. It will be argued that the influence of gender is crucial in understanding why the women chose this demanding form of practice.

In addition, what is known about the domestic division of labour and its part in controlling women's options outside the home has been well

documented. We also know about women's strategies for reconciling their two work roles in the 'public' and 'private' domains. What we do not know about is what happens when women take ultimate responsibility in the 'female' domestic role - how do they manage their demanding 'male' work role when that, too, involves total responsibility? And how do these two 'time-intruding' roles interact and how do women manage the actual 'time-intruding' link or interface between their two work roles? And what of the female conducting her demanding 'male' work role at unsocial hours in the exposed and unsafe male controlled arena? What then of their 'male' role?

The choice of a methodology to support a research aim is important and controversial. Some have argued that the qualitative approach complements the feminist motive of keeping women central and being concerned with "sex as a variable" and "men and women as people" (McKee, 1985:17). However, qualitative approaches do not presuppose a feminist perspective, but rather feminists permeate the sexist traditions of such approaches. As Rose has concluded:

> A feminist epistemology derived from women's labour in the world must represent a more complete materialism and a truer knowledge. Such an epistemology transcends dichotomies, insists on the scientific validity of the subjective and the need to unite cognitive and affective domains; it emphasizes holism, harmony and complexity rather than reductionism, domination and linearity. In this it builds on traditions in the sciences which have always been present within the dominant culture. (1986: 179).

The present research aims to get close to women's perceptions of their experience and is concerned "with processes rather than patterns, and with exploration rather than generalization." (McKee, 1985: 18).

The findings are based on in-depth interviews and involvement with single-handed women GPs in the Midlands. They are an amalgam of feminist and non-feminist perceptions of the world: of the women GPs' and the author's interpretations of subjective realities. In so doing they explore and present women's own experience.

The thesis begins by developing an appreciation of the incorporation of women into the medical profession and at the factors which have affected their performance within it (chapter 2). In chapter 3 a characterisation of some of the main aspects of general practice is provided, in order to set later discussions in their appropriate context. The material includes a recognition of some of the contradictions and problems within general practice. A documentation of the 'personal account' approach to the conduct and analysis of the study is provided in chapter 4. It is shown how the research 'problem' emerged and places the research process in a feminist perspective.

The results of the investigation are presented in chapters 5-12. The flavour of the research is indicated by the case studies of three of the women GPs' lives and observations of their practice which appear in chapter 5. Chapter 6 follows the women's path to general practice, covering the decision to practise medicine, training and the hospital career until entry into general practice. Experiences of general practice in groups and partnerships are explored in chapter 7 especially with regard to the way their experiences were central in leading the women to practise single-handed. In chapter 8, the single-handed practices of the women GPs are examined. Chapters 9 and 10 move from the professional into the domestic setting by exposing the fallacy of the separation of the 'public' and the 'private'. The link

between the practice and home lives of the women GPs in terms of their arrangements for, and experiences of, out-of-hours cover is discussed in chapter 9, and their home lives in chapter 10. Chapter 11 draws on discussions of the general attitudes and perceptions of the women GPs and their aspirations and plans for the future. The interaction of gender and ethnicity are assessed in the lives of the Asian women doctors in chapter 12. At all times the discussions in chapters 2-12 are set against the characterisation of the 'family doctor' presented in this opening chapter. The overall conclusions of the study are discussed finally in chapter 13.

The Appendices reproduce (A) the letter sent to the GPs, (B) an outline of the topics discussed with the women GPs; and (D) Paying the Professions (an extract from the 1986 Government Green Paper on Primary Health Care). In (C) are 'contextual outlines' of each of the 29 single-handed women GPs for referral throughout the thesis.

CHAPTER TWO

WOMEN IN MEDICINE: WOMEN IN GENERAL PRACTICE

In conducting a study on single-handed women GPs, it is appropriate to put the present position of such doctors into an historical context. The study looks first at the influences of past experience on present day practice by exploring such issues as medical education, the specialties women work in and the impact of family commitments. In addition, the specialty of general practice is examined in greater depth, focussing on how women have been accommodated as GPs and how their presence affects their patients. This leads to a discussion of "sex-stereotyping" - one of the central themes of the thesis.

2.1 Medicine: a male-dominated profession

There are a number of important implications for women, in medicine being defined as male-dominated, as Ward and Silverstone (1980: 16) have observed. The profession of medicine - or doctoring - has been described as one of the 'traditional' professions (Ward and Silverstone, 1980: 9). Elliott (1972) defines the 'traditional' professions as having five distinguishing characteristics. They have (1) a basis of systematic theory and wide knowledge of a specialised technique obtained by a long period of intensive training; (2) authority based on this knowledge and recognised by both the clientele of the professional group and the larger community; (3) autonomy (based on the claim of unique expertise) in the exercise of the skills, in the training of new entrants, and in the evaluation and control of practice of

the profession; (4) a code of ethics and professional culture developed by formal professional associations, inculcated by professional schools, and regulating the relations of professionals with clients and with colleagues; and (5) an intense commitment to the profession based on the required long investment in professional training and on a strong sense of identification with the work. One aspect of the characterisation of the professional which has been implicitly (rather than explicitly) omitted from this definition, but which clearly stems from it, is that the professional is **male** (Patterson and Engelberg, 1978). So that, in effect, a woman professional is viewed as deviant from the traditional images of her place in society (Epstein 1970). Leeson and Gray (1978) suggest that the relative or total exclusion of women from the ranks of the healers seems to have been an integral part of the process of professionalisation. Whilst other writers adopt different definitions of the term 'profession', the essential 'maleness' is not discussed in such definitions. The position is further exacerbated by the use of the term 'semi-profession'. Etzioni defines these thus:

> Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge and they have less autonomy from societal control than 'the' professions. (1969: v)

However, here again, what is left out from this definition, as Simpson and Simpson (1969) have suggested, is that the semi-professions are not full professions because they are female-dominated. Many of the semi-professions are medically oriented, so that women doctors are particularly likely to be devalued in attempting to be recognised as 'full' professionals. A male-dominated profession such as medicine, then, with the increasing recruitment of women (see below) has to reconcile its male-dominated and

professional status with the undermining influence (Elliott 1972) of women increasingly joining its ranks. Despite what some authors have described as, and what evidence shows is, an improvement of the position of women within medicine, this has occurred without much denting of the fabric of its male-domination.

The position of women in medicine today cannot be understood without considering the history of their struggles to gain admittance to the profession. Those brave pioneers such as Sophia Jex-Blake, Elizabeth Blackwell and Elizabeth Garrett-Anderson were struggling at a time when the predominating attitudes to women in medicine were those that were aired in the BMJ in 1877. The article started with the statement:

> Of all the professions into which women might seek to be admitted, that of medicine is, in my opinion, the least suitable.
>
> (BMJ 30 April 1977)[1]

"Physical incapacity" is seen as a prime reason for excluding women from joining the medical profession. The question is asked:

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1 A suggestion which is also made in this article is that a profession such as the law would be more suitable for women to enter; in the light of the current situation, this is surprising. Women make up only 12 per cent of lawyers and the legal profession is, on the basis of recent figures, more difficult for women to succeed in than is medicine.

The 1877 article states:

> There is no physical difficulty to prevent a woman from performing the duties of attorney or solicitor; and even at the bar there is no reason as regards physical capacity, that she should not exercise as a barrister the persuasive powers of her sex.

> How is it possible for a woman on a rough and perhaps wintry night to ride some 5 or 6 miles in an exposed country, to visit a patient who may require at the end of such a journey a doctor with clear judgement and steady hand?

There are further arguments against encouraging women doctors in the article. Even those women who do not marry, 'spinster aunts' as they are called, have a valuable role to play in the family, which does not necessitate them being driven "to seek occupation in a sphere outside their own family".

They can assist

> their brothers and sisters in the management of their families when from sickness or other cause the natural protector is unable to take care of them ... We have frequent reason to lament that there is no spinster aunt or sister at hand to take charge of some poor invalid.

To fully comprehend the odds which women a century ago were up against it is helpful to quote the end of the article in full:

> The work of women is not less dignified, and should not be less intellectual, than that of men; but they are protected against the rough and stormy conditions to which men are exposed. These asperities of life would break down the more sensitive and delicate nature of a cultivated woman, and would render her incapable of discharging her duties. Beyond this, there is the still weightier reason that it is scarcely possible for a woman to go through a course of medical education without losing that simplicity and purity of character which we so much value; there are subjects which cannot be discussed with freedom between the two sexes, and there are many matters with which women had better not be acquainted. I think, therefore, that in the truest interest of women it is better that they should not practise the medical profession.

Sachs and Wilson bring out a similar point in discussing how women tried to get into medical school and, when they were rebuffed, took the matter to the courts. As they say:

> Without embarrassment or apology, the judges painted a picture of women being too delicate and refined to undertake public functions and accordingly classified them legally alongside the insane and insolvent, and even in one case alongside the inanimate.
>
> (1978: 6)

Further discussion of these attitudes would not be particularly useful, since one can read this now with genuine amazement. Nevertheless such attitudes were the bases for those of today towards women in medicine, the bases on which the profession is moulded. Consequently, understanding the attitudes of a century ago help clarify how the profession has developed and give an understanding to the present day attitudes. The part which women play in medicine today has been hard won against the prevailing chauvinistic attitudes within the profession, such as those expressed in the BMJ article of 1877.

Recent literature, however, demonstrates that while women have gained substantially since that time they remain in hierarchical terms members of a profession which is male-dominated. Several authors, with the aid of secondary literature, show this (e.g. Elston, 1977, 1980; Leeson and Gray, 1978; Lorber, 1984, and others). I shall use these secondary literature sources to explore the development of the position of women doctors within the medical profession, in order to explain their present status within it, in preparation for arguments developed later in this study.

Elston (1977, 1980) uses an historical analysis to illuminate the strategies by which male supremacy is built up and maintained within the medical profession. Although she looks briefly at the position for women from the 10th to 18th centuries, it was in the 19th century that the women pioneers were able to challenge the establishment by finding loopholes in the regulations and legislation to enable them to enter medical schools and to acquire medical education,[2] although this by no means meant a general acceptance within the main stream of the profession. The 1877 BMJ article quoted earlier indicates the prevailing attitudes within the profession in the 19th century. Although women had always practised medicine,[3] it was perhaps the founding of the London School of Medicine for Women in 1874, clinical facilities being provided at the Royal Free Hospital from 1876, which helped to produce most female doctors over the next thirty years (Elston 1980). The Registered Medical Women's Association of London was founded in 1879 which by 1910 had 200 members. By 1917 the Federation of Medical Women, or Medical Women's Federation (MWF) as it is known today, was pursuing the interests of women in the medical profession in Britain.

The First World War provided some impetus to women entering and working in medicine, but this was shortlived (Elston, 1977, 1980), in that most women's places in medical schools were withdrawn in favour of men after the war. By 1921 women constituted 10 per cent of those in medical school and 5.4 per cent of those in active civilian practice. By 1931 women

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2 See Sachs and Wilson (1978) above.

3 E.g. when the Guild of Surgeons was first founded in 1389 it had a few women members.

constituted 10 per cent of practising doctors, and medical students were slowly rising to the 1938 figure of 15 per cent. At this time some medical schools found women students more acceptable than others and, as Elston points out, in the Scottish and provincial schools nearly 20 per cent of students were women, but in London, excluding the Royal Free, there were only 6 per cent female students. London schools, it should be noted, had 40 per cent of all medical students, and their virtual exclusion of women students was significant, since they were viewed as the most prestigious schools.

In preparation for the introduction of the National Health Service, the Goodenough Committee reported in 1944 on what kind of medical education would be appropriate. The Report held that no barriers other than aptitude should operate in the selection of students for medical schools. (At this time ten London schools, including the all female Royal Free, were single sex institutions). Government grants were to be made to encourage 'a reasonable proportion of women students' (Goodenough Report, 1944). This 'reasonable proportion' was taken to be the pre-war figure of 15 per cent, and became a minimum quota, although little attempt was made to ensure quotas were kept to in individual schools. Even 20 years after the Goodenough Report, the London medical schools showed markedly lower levels of female entry. For example in 1967 Leeds admitted 34.8 per cent women students, while the London Hospital admitted 11.3 per cent.[4]

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4 Epstein (1970) explains how senior, male members of professions have control over actual admission to them and tend to select in their own image, i.e. they select men like themselves. She shows the difficulty for women in getting past these male "gatekeepers" at all stages of their careers. This is also discussed by Becker (1961) when he explores entry into the male medical culture.

By the end of the Second World War about 25 per cent of medical students were women and 15 per cent of active civilian doctors, although there was substantial variation between schools, as mentioned above. In 1968, when the Royal Commission on Medical Education reported, 25 per cent was seen as a 'high' percentage for women in medical schools and no recommendations for the abolition of these 'de facto' quotas was made, although it was noted that higher standards of entry were normally required of women. There was no formal abolition of quotas until recommended by the 1973 Committee of Vice-Chancellors and Principals. Nor for some time did the Sex Discrimination Act seem to have had a significant impact on the overall percentage of women in medical schools - which had risen to 37.8 per cent by 1978 (Elston, 1980) but is now 44 per cent (1986). Elston (1977, 1980) sees the increase in the proportion of women as being due to three factors: the expansion in overall numbers at a time when applications from women were growing faster than those of men; the increasing pressure on places; and the increasing selection by examination results. But she suggests that the formal abolition of quotas cannot wholly explain the rise in numbers and proportion of women at medical school over the past decade or so, since the rise partly predates this.

Of those women who actually go to medical school it is apparent that they, and society at large, see medicine as a more suitable career for a woman than pure science or engineering (Kelly, 1975). These women are also more likely to be drawn from higher status backgrounds than are men, and are also less likely to fail at examinations. As Elston (1980) remarks, though, this early promise is not on the whole reflected in later working life, as will become evident later. The early promise which gains entry into medical

school is quickly affected, however successfully a women performs in that context, by a background of a student culture which is male, and the essential 'maleness' of the profession continues to affect them into and throughout the professional career (Becker, 1961; Quandango 1976; Young, 1981)

Academic success is only part of the key to a successful medical career. Campbell's (1973) study of the US situation shows the problems for American women medical students in terms of discrimination within medical schools, but there is no equivalent British study. Elston (1980) cites studies which demonstrate that women professionals in a number of fields are often excluded from key learning contexts - informal settings such as clubs, changing rooms and bars - and therefore may fail to learn the importance of informal contacts and therefore may not develop them (Lorber, 1975, 1984; Smith, 1976). Domestic commitments, too, can limit out of hours interaction with peers and prospective patrons, and women are either formally or informally excluded from this 'inner fraternity' and hence their career opportunities are more narrowly circumscribed (Elston 1977, 1980; Epstein 1970; Lorber, 1975, 1984)[5]

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5 This is because of the "protege system" which is typical of professions such as medicine and the law, whereby more senior members of a profession will sponsor students or more junior members of the profession, having identified them as potentially worth encouraging. In turn, the student or junior doctors or lawyers will attempt to cultivate such sponsors. Women are inherently less likely to attract such interest or sponsorship, nor are they likely to be able to cultivate the 'right' people very easily. The importance of sponsors in medical careers is discussed by Hall (1948).

Several studies show that despite women having a better academic record in medical school men progress further and more quickly though the various grades to consultant levels, and have more postgraduate qualifications (Jefferys and Elliott, 1966; Stanley and Last, 1968; Aird and Silver, 1971; Beaumont, 1978). The Medical Careers study (Johnson and Elston, 1980) provided some important data on post-graduate qualifications - 5 per cent of women and 11 per cent of men held MRCP (Member of the Royal College of Physicians); no women and 12.5 per cent of men FRCS (Fellow of the Royal College of Surgeons); 17 per cent of women and 32 per cent of men held some other college or faculty membership. However, 53 per cent of women and 46 per cent of men held some form of Diploma,[6] most commonly in obstetrics, anaesthetics and, for women, in child health. The significance of this will become apparent later, when specialisation is discussed.

2.2 The impact of family commitment

While 19th century objections to women in the medical profession were focussed around the unsexing effects of exposure to anatomy and so on, they are now concerned with the question of what is termed 'wastage'. It has been held that women do not use their medical training to the full and it is considered undesirable to waste scarce resources on women who will give priority to domestic commitments (Elston 1977, 1980). This section, then, explores the extent to which women do give priority to family and domestic commitments. It also suggests that because of normative

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6 A Diploma is a 'lower' qualification than either Membership or Fellowship of a College.

expectations of their role in the home, women's opportunities in terms of further training and their career are circumscribed and limited. Women often find themselves dependent on the "dominant view" of the men who hold the positions of power in the medical profession. Coser and Rokoff (1971) have referred to this as the "cultural mandate", which prescribes that the primary allegiance of women is to have a family and that men provide the family with economic support and social status. Consequently women are put in an invidious position which forces them to choose certain courses of action: they can remain single (as most of the women pioneers did) or childless (Elizabeth Garrett-Anderson) and bear the social cost and stigma entailed; they can reproduce and pursue their careers (and be condemned as inadequate wives and mothers), or they can give up their work to minister to their husbands and children and be condemned for having wasted the nation's investment in them and for having kept a prospective male doctor out of medical school by selfishly occupying his place (Leeson and Gray, 1978)

The relevance of such choices has been examined by Stanley and Last (1968) who showed little differences in the work status, postgraduate training, or career aspirations of single men and women doctors. But marriage altered this: married men had most often firmly decided on a specialism, and more of these than of single men had opted for general practice. A large proportion of married women had not firmly decided on their specialisms, and those who had decided were more likely than single women to prefer general practice and public health. Patterson and Engelberg (1978) suggest that as long as women are held to be primarily responsible for running the household and rearing the children they will have to devote all their efforts to managing their careers in order simply to

maintain them. They are thus much less likely to make it to the top. The dual time demands which are made on women doctors are contradictory in a deep, normative sense too (Bourne and Wikler, 1978) in the light of the sorts of male attitudes that many women doctors face such as that of the dean of a medical school with 48 per cent female medical students:

> ....if a woman wants to undertake a career and have a marriage, then there's conflict, and given our social structure, most men expect their wives to be wives and not professional partners as such. Most men would want to have a family, and I guess so would most women, and so it throws a considerable strain on a female which many females find a great deal of difficulty coping with. And so you find an intelligent woman who also wants to be a mother having difficulty in practising proper motherhood, short of using creches or nannies, or grandmothers, and never seeing their children, and again, my belief is that that's bad for a whole generation of children growing up in intelligent, professional households who are not subject to the kind of mother care that I would think would be appropriate in the first ten years of life.
>
> (Gathorne-Hardy, 1984: 259)

It is little wonder with such views that this so-called 'wastage' of women doctors occurs. However, little is ever considered about the issue of men's wastage from NHS. For instance, women live longer than men, men are struck off the Medical Register more often, men are more likely to emigrate (in Stanley and Last's study (1968) the percentage of men who emigrated as against that of women not in paid employment was practically the same) or to practise privately. Loss of medical time through balancing family commitments may be counteracted overall by male doctors' greater involvement in 'medical politics' (Elston, 1977). However, commitment to the family by women and the use of the 'family situation' as the sole

independent variable relating to women's working patterns can easily become a legitimation of discrimination against women rather than a 'partial' explanation of 'failure' to pursue the full 'career' (Smith, 1976). It is apparent that the problems that having a family produce in relation to professional life have increased for the simple reason that a much higher proportion of professional women marry than did so previously (Elston 1980).

Various studies demonstrate that the number of women doctors working full-time has risen in every age group, amongst single women, childless married women and married women with children (Elston 1980). It is also apparent, though, that of these the age of marriage is several years older, and a greater proportion begin their families after the age of thirty than do their non-medical sisters (Leeson and Gray, 1978). But having children is seen as the single most important factor affecting the employment pattern of women doctors although marriage itself has a significant effect on careers, the impact is very much greater for women than for men (Elston, 1980).

Another important consideration is the impact of the domestic situation and the division of labour in the home. It is evident that a fairly traditional pattern of responsibility occurs in most homes with women having responsibility for the majority of daily tasks. But many professional women in particular suffer an insoluble dilemma between dedication to their profession and allegiance to the family, and these are not easily reconciled (Coser and Rokoff, 1971). It has been suggested that the children of a doctor's family suffer in a qualitatively different way from the children of other professional families, in that patients' health may get preferential

treatment at the expense of these children's health, which can in consequence be neglected (Nelson, 1981; Pereira Gray 1982). The whole question of the domestic division of labour and its reconciliation with professional life will be discussed more fully in a later chapter (see chapter 10).

2.3 Where women work

The areas of medicine where women work and their levels of attainment demonstrate further differences between the careers of men and women doctors. The medical labour market, particularly in hospital, resembles a dual labour market: a higher paid primary sector with good prospects for advancement, and a secondary sector of lower paid posts not arranged in a career ladder wherein women (and overseas) doctors are disproportionately concentrated (Elston 1977, 1980).[7] What becomes apparent from an examination of various studies is the decreasing proportion of women at progressively higher levels of the training ladder. Women are in fact over-represented in the sub-consultant career grades (e.g. Medical Assistant) and it has often been suggested that these permanent grades with less than full consultant responsibility are especially suitable for women with domestic commitments. The new hospital practitioner grade which is designed to better the position of general practitioners in hospitals has not attracted many women. The scheme was initially limited to principals in general practice who had had two years appropriate hospital practice - mostly men. Although concessions were made for part-time practice, recruitment to the grade has been slow overall, but especially so for women.

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7 This is the case in the legal profession too - see, Spencer and Podmore, 1986.

Table 2.1

WOMEN HOSPITAL MEDICAL STAFF
(England and Wales Only) - 1985

Total Staff Numbers	Women Numbers	Women % of Grade	GRADE
34,070	7,327	21.5	All grades - SHO and above
14,242	1,837	12.9	Consultants
3,284	811	24.7	Senior Registrars
6,129	1,343	21.9	Registrars
10,415	3,336	32.0	Senior House Officers

Compiled from: Health Trends, (1986)

In Table 2.1 it can be seen that while women make up 21.5 per cent of hospital doctors of SHO grade and above; they constitute 32 per cent of those at SHO level, and only 12.9 per cent of those at consultant level. However, Table 2.2 shows how consultants are distributed between specialties, with the greatest concentration of women consultants working in psychiatry/mental handicap (22.2%), pathology (19%), anaesthetics (18.8%), and radiology/radiotherapy (17.6%). In surgical specialties, though, women make up only 2.2 per cent of consultants, and in obstetrics and gynaecology (where it might be expected that women would be found) only 11.7 per cent of consultants are women. In effect, these figures confirm medicine as male-dominated and particularly at consultant levels with only 12.9 per cent of consultants being women.

Table 2.2

CONSULTANTS BY SPECIALTY
(England and Wales Only) - 1985

	Total numbers	Total females	Percentage females
All specialties	14,242	1,837	12.9
Medical group	3,684	372	10.1
Surgical group	2,999	66	2.2
Accident and Emergency	164	14	8.5
Obstetrics and gynaecology	772	90	11.7
Anaesthetics	1,912	360	18.8
Radiology/ radiotherapy	1,214	214	17.6
Pathology group	1,589	302	19.0
Psychiatry/mental handicap	1,863	413	22.2
Other	45	6	13.3

Complied from: Health Trends (1986)

As suggested above women are not evenly distributed across all fields of medicine. Elston (1977, 1980) believes that this is not solely the outcome of 'choice'; i.e. the exercise of personal preference is not the main factor in determining where women, and indeed men, work. For example, general practice has long been thought to be a suitable field for married women doctors in that flexible working arrangements may be possible. Elston (1980) comments on the advantage of general practice for women with children, since they can do locum work while domestic commitments are at their heaviest, and then seek a permanent practice position.

Women are well represented in local authority and community and school health services, 60 per cent of such posts being occupied by women (Day 1982). They are not well represented in the high grades and are most plentiful in the Community Health Service created by the NHS reorganisation of 1974 which Elston has suggested are "dead end" jobs.[8] In effect the special requirements of women doctors were ignored during the NHS reorganisation. However, community medicine is a 'shortage' specialty in that there are currently unfilled posts and a shortage of doctors in training. This is a characteristic of most of the fields in which women doctors are comparatively well represented (Elston 1980).

While women are not evenly distributed across the various fields of medicine, this is not the outcome of direct choice. Quandango found that women's specialty choices in the US may be the result of a subtle discrimination that encourages them to enter certain specialties, while discouraging them from others. She noted:

> Rejection in some areas, encouragement in others and a tendency to avoid open confrontations all work to affect the specialty choice of women physicians and ultimately their distribution in the labor force (1976: 451)

Similar forces are at play in the UK and women are less likely than men to be in their first choice of specialty (Hutt et al 1979), general practice, for example, ofen being a second choice to hospital medicine (Turner 1979).

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8 More recent reorganisation has in effect eliminated some of these "dead end" posts.

For a high percentage of women, family commitments may be an important factor determining the direction of their careers. In this instance, men and women's career choices take place against different constraints and for many over a different time scale. Women are engaging in childbearing at the critical period and age when most male doctors make their career choices - during the decade after qualification (Elston, 1980).[9] In a study of women and medicine it was shown that for as many as two thirds of women doctors who do not work, the reasons for not doing so included the lack of a suitable job (Leeson and Gray, 1978).

In hospital medicine women are almost totally absent from surgical career posts (Adelman, 1983), but comparatively well represented in anaesthetics, radiology, mental handicap and children's mental illness (Mackie and Pattullo, 1977). Reasons put forward for this are that women have characteristics desirable for working in such specialties. However, some of women's supposed innate characteristics (such as manual dexterity, for example) are not seen as qualification for specialising in plastics or neurosurgery, nor is their supposed special knowledge employed in obstetrics, gynaecology or paediatrics (Young, 1981). Some of the specialities where women are best represented also have working arrangements which permit resolution of the 'role conflict' between work and home.

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9 The same is true for women in the civil service, see Walters (1987: 21).

Those women who do enter and achieve high status in fields where they are less well represented are on the whole those without family commitments since there is little provision for part-time work. It also seems apparent that women are more plentiful in specialties which are underfinanced (the 'shortage' specialties, mentioned above).[10] The 'shortage' specialties which tend to have a bigger proportion of women consultants have gone furthest in developing part-time training and working possibilities. Such specialties are generally not regarded as being the most interesting or advanced. Indeed, some areas which tend to be the province of women doctors in the UK are in some countries carried out by nurse specialists. This can be linked to the notion that high proportions of women in an occupation or profession lower its status and rewards. Women doctors tend to be less well paid than men because of their skewed distribution across the professional hierarchy, despite NHS equal pay policies. And men are also more likely to be influenced by remuneration and status factors in career choice than women.

In order to reconcile work and family, provision has been made in some specialties for part-time training and/or work. But while some of these options are open only to women and only in certain specialties, women remain at a disadvantage. If men are not afforded the same opportunities they cannot fully participate in child care. Another option for women primarily designed to encourage those with family responsibilities to keep up-to-date is the Doctors' Retainer Scheme.[11] Under this Schemes, a sum

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10 See Elston (1980: 133) for a brief explanation of shortage specialties.

11 This is no longer called the Women Doctors' Retainer Scheme, since it is open to all who are out of medical practice over a period of time and could potentially attract men too, for reasons other than domestic ones.

of money per annum is received to cover registration and medical defence fees and one journal subscription, with the undertaking to attend at least five educational sessions a year and work up to one day a week. Beaumont (1978) found 25 per cent of respondents in her survey of the Thames Region had never heard of the Scheme. In 1978 there was only a total of 224 doctors enrolled on it. There are also part-time (re)training schemes, but such opportunities are concentrated in 'shortage' specialties (Leeson and Gray, 1978). It is in any case apparent that a large proportion of women cannot find part-time posts after completing their part-time training (Henryk-Gutt and Silverstone, 1976). This indicates an inflexibility in the reorganisation of certain specialties to fit in with the needs of those who work in it. The same has been shown in other professions, such as the civil service, where Walters notes:

> Despite the formal civil service policy of encouraging provision of part-time work, the woman higher civil servant has no kind of guarantee that should she seek such arrangements they will be forthcoming. Formal statements and collective wisdom in the higher civil service emphasize the severe limits that the nature of the occupation places on the development of opportunities for part-time working. The argument is that real administrative work is incapable of being organized on a part-time basis because it involves a continuous meshing-in with a seamless flow of information and events. Normatively, part-time working is seen to run counter to the ethic of accessibility, and the convention of 'not clock-watching'. (1987: 26)

This is indicative of the medical and a number of other professions.

From the discussion so far it is clear that while women are now entering medicine in greater numbers than ever (44 per cent of medical school

entrants in 1986) this is more the result of changes in the wider society than the action of enlightened medical educators (Elston, 1980).

In order to examine some of the issues raised in more detail, it is pertinent to concentrate on the position of women general practitioners, since this is viewed as a suitable specialty for women, particularly married women with children (Boswood, 1982). Looking at the position of women in general practice is illuminating in that it exposes many aspects and problem areas for women in the occupational sphere generally and will provide a background for the presentation of the data on single-handed women GPs.

2.4 General Practice: a career for women?

Women comprised 14 per cent of general practitioners in Great Britain in 1976, and 13.6 per cent of 'unrestricted principals'. Although evidence suggests that both these figures are on the increase, ten years later, in 1986 there were still only 18 per cent of GPs who were women. As has been suggested, general practice is viewed as particularly suitable for married women and those with children because of its possibilities for flexible working arrangements - locum work and so on. Rhodes claims that more and more women are working in general practice because work in it is "sometimes easier to arrange to suit a variety of circumstances, including running a home, than work as a consultant in hospital" (1983b: 964). However, nothwithstanding Rhodes' comment, less than one general practitioner in five is a woman. This could be due to a number of factors. First, women working full-time seem to have less chance of finding a partnership than their male colleagues. Second, there is a lack of part-time jobs in this area despite the fact that part-time training is well

established (see above) (McPherson and Small, 1980). Third, the experience that some women may have working in general practice may not attract them to it (see Lawrence 1987, and chapter 7 below). It is also suggested that the lack of a positive attitude within the profession towards women in medicine could be a factor (Savage and Wilson,1977).

A systematic attempt to document the advantages, that women bring to general practice rather than the disadvantages, is recommended by an Editorial in the Journal of the Royal College of General Practitioners (1979), which goes on to say that objective evidence of women GPs' own rather special role has so far not been demonstrated. The Editorial later proposed this special role may be related to the "nurturative female mentality" of women and that this is particularly desirable in many circumstances in general practice. This study and other literature, however, challenges such a suggestion. For example, other research gives a more differentiated view of the personality of career women and reappraises the concepts of masculine and feminine characteristics and their roles in the personality (Helson, 1972). In fact, according to Cartwright and Anderson (1981) there is no evidence that women GPs adopt a more expressive role than their male colleagues. They also go on to observe from their study that what was noticeable was the **lack** of difference between men and women GPs. In fact the main difference seemed to be that women doctors had rather fewer patients than male doctors. However, while some studies of women in the professions suggest that women are seen as more sympathetic and hence more suited to a caring role in their professional lives (Fogarty, Allen and Walters, 1981) this is also a need which has been voiced by women consulters of professional help. For example, Jefferys and Sachs (1983: 296) found a

tendency for women patients to be rather more inclined than men patients to choose kindness rather than cleverness as requirements they felt they need from their GPs. As Jefferys and Sachs went on to note, such a response is to be expected because it fits in with a common sex stereotyping, such as that found by Fogarty, Allen and Walters (1981) in various professions and Podmore and Spencer (1982) in the legal profession.

Marinker suggests, in discussing sex-stereotyping of women GPs, that all doctors have both 'male' and 'female' characteristics, and that what:

> is (so-called) feminine in medical practice is not necessarily confined to, or most often found among, women doctors. Some of the most instrumental not to say aggressive, doctors I have known have been women (1975: 3).

Sex-stereotyping of this sort is, in effect, used to channel women into appropriate specialties. There is no evidence in terms of traits, personality, and so on, that women differ greatly from men. Leeson and Gray (1978) also reject the sex-stereotyping which assumes that women alone can perform 'caring' tasks but believe that with better utilization of skills offered by a wide range of health workers, a majority of whom are woman, and of women doctors, a better attempt might be made at tackling many of the health problems of today. Marinker sees the problem of resolving many of the problems of general practice today as lying in the confusion of "so-called feminine characteristics with the state of being a woman" (1975: 3) which would mean that general practice needs many more women practitioners if it is to develop the knowledge, skills, and attitudes which we believe are important for patient care. He believes that, when the mistaken ideas of sex-stereotyping of women GPs are recognised, then

women will be represented in practice in the same proportion as they are represented in society.

Marinker also proposed that suggestions that women GPs, because they are women, are good at running family planning clinics and well baby clinics, and that other women like to see them when their children are not well or when they have a gynaecological problem, is mistaken. "These very prevalent views", he says, "are of course quite unconnected with any empirical research into patterns of attendance and morbidity" (1975: 3). (As will be seen no patterns of attendance or mobidity are presented in this thesis.) The earlier mentioned JRCGPs Editorial believes that women GPs are ideally suited to certain areas of medical practice because there are more women patients and "it is possible that women doctors understand many of their complaints more quickly, if not more deeply, than men" (1979: 196). This is because of the shared experiences of "menstruation, pregnancy, labour and child-rearing", a factor which Young (1981) also raises. The article goes on to say:

> The large number of conditions which are exclusive to the female sex, including the mass of gynaecological complaints seems ideally suited to women physicians who are also more experienced and better with children than men (JRCGPs,1979: 196).

It is certainly true that women are the ones who consult a GP most often, not only for their own health but for other members of their family, and this would perhaps have some effect on the preference or otherwise for a woman GP (Graham, 1984). In Lawson's (1980) study of patients' attitudes to doctors 4 per cent of respondents preferred a female doctor overall, and 14 per cent for some occasions, depending on the nature of the illness. This

does not however mean that either figure consists of all women, although it is likely that a majority are. Another aspect of patients' preferences for either men or women GPs is looked at in Hull and Hull's (1984) study of the length of doctors' consulting times. More than half of the young women who took part in the survey expressed difficulty in communicating their problems to their doctor. The authors suggest that this may be related to the fact that most of the doctors were male, although the one woman GP included in the study did not show any evidence of better communication than the male doctors (Hull and Hull, 1984).

Bhargava makes a distinction between sex-stereotyping and sex congruency. Sex-stereotyping is seen as being rooted in and stemming from the nature of a society, particularly its normative structure. Thus the female stereotyping of obstetrics and gynaecology in India is rooted in the widely accepted norm of sex segregation. Sex-congruency refers to the perceived compatibility between sex role expectations and the demands of a specialty. Thus, for example, the argument that pathology, ophthalmology, plastic surgery and anaesthetics are particularly suitable for married females, basically refers to certain dimensions of these specialties, such as predictable hours and relatively few emergencies, which are congruent with the woman's role as mother and wife (1983: 1017). Thus, ethnicity and culture can play a part in consulting patterns and expectations of patients, and their desire for a woman GP. This aspect will be considered later in more detail in Chapter 12. The ideas discussed above are supported by the data in this study, where it will be shown how women GPs are channelled into certain directions in general practice by the attitudes of partners and assumed patients' views (see chapter 7).

Evidence suggests that, whether sex-stereotyping is evident in practice or not, i.e. whether women GPs are really more sensitive, caring etc is not the most important point. What is important is that expectations are that women physicians will have these characteristics. Grant shows this in a study of medical students, in which "self-ratings revealed few differences between men and women. Peer nominations, however, revealed a preponderance of male nominees in ten competence areas" (1983: 57). Competence dimensions tapped scientific/technical skills, dedication/commitment, and interpersonal skills. "Women dominated nominations only in the category of sensitivity to patients" (1983: 60). Grant concludes: "the data suggest that medical school peer groups share expectations about the competencies of men and women as physicians which are consistent with generalized sex stereotypes and career patterns of men and women physicians" (1983: 60). This suggests that it is the **expectations** of men and women not the **actuality** which is relevant in discussion of sex-stereotyping. Cartwright and Anderson's (1981) study, however, does demonstrate some preference by women patients for a woman GP. Although the reasons for this were not examined, in the sample used three fifths of the women doctors' patients were women (this had dropped from three quarters in Cartwright's (1967) earlier study of general practice) while men doctors had 51 per cent female patients. It is also interesting to note that in the 1977 study, women doctors had rather younger patients than their male colleagues: the proportion under 55 was 62 per cent for men, 75 per cent for women doctors (Cartwright and Anderson 1981). This may be because young people are less bound by the traditional stereotypes of women. Cartwright and Anderson also found that patients had been with their female doctors for a shorter time: 14 per cent of them had been with the doctor for fifteen years or more compared with 32 per

cent of those with male doctors. This may suggest a more recent trend of patients to prefer a woman doctor. One can only surmise at present whether this means that there could be a growing patient demand for women doctors in the future. This potential demand for women doctors does not differentiate between male and female patients, but would be an interesting trend to document by gender, noting, too, the reasons for preference, if any.

The question of patient preferences is also examined by Gray (1982). She counters some of the arguments put forward so far by suggesting four propositions on the effect of the doctor's sex on the doctor-patient relationship. First, she suggests, that women doctors and medical students are different from their male counterparts in certain respects, which seem to reflect differences in male and female socialization; second, that the qualities which women doctors tend to have, and which women in general tend to have, correspond with the qualities patients desire in a good doctor; third, that female patients are more likely than male patients to prefer women doctors, and in effect recognize the link between the first and second propositions. Male patients, although they seek similar characteristics in their doctor, are less likely to associate these characteristics with a woman. Fourth, the outcome of doctor-patient exchanges is significantly different in a number of respects according to whether the doctor is a man or a woman. Communication is easier, more time is given, drugs are less frequently dispensed and women patients are treated more seriously if the doctor is a woman. Barrett and Roberts (1978) and Roberts (1985) show how many middle-aged women patients are not taken seriously by male GPs and are often treated as intrinsically sick, rather than rejecting the social pressures put on them to conform to female

stereotypical roles in the home. This confirms, in effect, Gray's conclusion that "it would seem to make sense for patients, particularly women, to seek out women doctors" (1982: 169). She suggests that this is because women doctors bring into their professional lives certain features of female socialization which are positive, and that such attributes could well benefit male doctors.

> In other words, if it is true that not all aspects of female socialization are negative, then not all aspects of male socialization are positive; male doctors and their patients may suffer from patterns of socilization which encourage men to be tough and unemotional (1982: 169).

She also suggests that male doctors would do well to gain such benefits of female socialization as "care, warmth, patience and love" (1982: 169)

Young (1981) suggests that there is a dichotomy between being a woman and being a doctor because of the male orientation of the medical profession, but that this is less noticeable in general practice than in hospitals and other areas of medicine:

> This is because the relationship between doctor and patient is more intimate, more trusting and more lasting, and because GPs work one to one with their patients and are asked to meet very real demands day-to-day, whether 'trivial' or not, whether emotional, social or physical" (1981: 155).

She suggests that there is less possibility of hiding behind a mythical image or totally physically-oriented way of thinking. It is still apparent, though, that many GPs maintain the distance imbued by hospital indoctrination at earlier stages of their careers, and this may be encouraged to some extent by large group and partnership practices, and health centres.

The rather special role of, or advantages that women can bring to general practice mentioned in the JRCGPs editorial, where objective evidence of this special role is requested, is academic if it is used to make women second class members of general practices (see chapter 7). Many examples in the literature document the progression towards the present position of women in general practice. Women's structural position within society in terms of their childbearing and caring roles has often been used negatively against them as GPs. However, they should now be in a position to use the positive changes that have occurred to enable them to move forwards. Discussion of the pros and cons of vocational training (VTS) for women comes later, but the fact that within the profession itself, VTS can be followed on a part-time basis, as can other postgraduate training courses in other areas of medicine, must bring closer a positive acceptance of women into general practice. Of course, it is still difficult, because there is no real legal obligation on the part of small concerns like general practices to include women as partners on an equal basis, but there should be less aversion to it. The main problems remain not so much those of training and wastage, (since these are to a large extent resolved) but those of women generally - childcare and domestic responsibility, especially during working time (and, particularly for GPs, out-of-hours cover). The generation of a positive attitude towards women doctors both within the medical profession generally, and more precisely within general practice is crucial and these aspects will be discussed in later chapters.

This chapter has covered a number of aspects of the careers of women doctors. In looking at the emergence of women doctors historically it has provided a background against which explanations of their present situation

can be measured. It has looked at how women entered the male-dominated profession of medicine, and at the influences of that past experience on present day practice, by exploring such issues as medical education, the specialties women work in and the impact of family commitments. It has then focussed on the specialty of general practice examining how women have been accommodated as GPs, and the effects of sex-stereotyping on relationships within general practice, and between women doctors and their patients. Both this and the next chapter, where the changing context of the organisation and structure of general practice is discussed, will contribute to an understanding of some of the data presented later.

CHAPTER THREE

THE CHANGING CONTEXT OF GENERAL PRACTICE

This chapter looks briefly at aspects of general practice, and particularly those characteristics which relate to single-handed practice. It takes as its theme the changing context of general practice so that each of the matters considered is examined both historically and developmentally to give a picture of how general practice has developed and changed in the forty years since the inception of the National Health Service. Among the matters considered are the system of remuneration for GPs, the Medical Practices Committee, the deputising service, general practice premises, the development of group practice, the Doctors' Retainer Scheme, the 1981 Acheson Report and retirement, and the 1986 Green Paper on Primary Health Care. The emphasis of the chapter is to treat general practice and single-handed general practice as the central focus, rather than gender issues which are considered elsewhere. This chapter thus aims to provide the background which will enable an understanding of the nature of general practice and its organisation, for the benefit of subsequent chapters.

3.1 Remuneration

The system of remuneration for general practitioners is an intrinsic factor in the structure and organisation of general practice and is considered first because it is so central to the nature of general practice. It is necessary to go back to 1948 and the beginning of the NHS to understand why GPs have a different relationship to the NHS from other health workers, and hence to understand the system of remuneration. At the time when discussions on

the structure of the NHS were in full swing, GPs refused to become employees of the NHS, and would only agree to cooperate on the understanding that they could retain their 'independent contractor' status. This independent contractor status which they achieved has had many implications for the structure and organisation of general practice. It in effect means that GPs are under contract to the state (in practice the Family Practitioner Committee, which acts on behalf of the government) to provide general medical services, so that each individual who lives within the area of the FPC, has access to adequate primary medical care. The FPC's control over the GP is limited, and includes such aspects as knowing from where the GP intends to practise (there are guidelines which determine whether an area is 'designated' or not (see section 3.2 below) and therefore how much need there is for a practice in certain areas (see section 3.4 below); that the premises are satisfactory; that the GP will be available for consultation at defined times; and that the GP's off-duty arrangements will not leave patients inadequately cared for. As Jones et al (1978) point out, the constraints within which a GP practises in the NHS inevitably limit freedom in not allowing practice from totally inadequate premises in such a way that patients receive totally inadequate care. But, nonetheless, the GP is no less independent than the industrialist whose factory must pass certain health regulations, or the owner of a guest-house whose building has to satisfy fire regulations. Significantly, the independent contractor status of GPs means that they are self-employed and these two factors mean that GPs have a very considerable degree of freedom of choice and control over the organisation of their practices in relation to both staff within the practice and patients (Jones et al, 1978).

In contracting with the NHS to provide services for patients GPs are in receipt of certain allowances and their income is generated from the system of remuneration laid down by the DHSS. GPs receive payments under a variety of headings:

(1) Basic and supplementary practice allowance - payable in full to all contractors who have lists of at least 1000 patients and on a sliding scale for those with lists below 1000;

(2) Capitation fees - payable for every patient on the doctor's list (and enhanced for some categories of patients);

(3) Various payments for items of service which the GP may undertake if s/he wishes and according to demand;

(4) Reimbursement of rent, rates, and 70 per cent of the salary of some ancillary staff. These are payable to any doctor with more than 100 patients on her/his list (subject to some conditions).

Under (1) the supplementary practice allowance is an extension of the basic practice allowance and is paid to GPs with more than 1000 patients who provide 'out-of-hours' service (i.e. night and weekend cover). Under (2) capitation fees are enhanced for patients aged 65 - 75, and a higher fee again is paid for those aged over 75. The supplementary capitation fee covers extra work done outside 'normal working hours' for patients on the GP's list over 1000. The Temporary Resident's Fee is paid for treating visitors who are in the district for more than 24 hours but less than three months. A Contraceptive Fee is also payable for contraceptive services to patients on the list who sign for these services. Under (3) items of service are paid for vaccination and immunisation; cervical cytology; night visits; maternity services and miscarriages; arrest of dental haemorrhage; emergency treatment; and anaesthetics.

Other sources of remuneration are based on GPs' qualifications, including: vocational training allowance (until all GPs are vocationally trained);[1] seniority allowance; postgraduate training allowance; and GP trainer allowance. In addition, fees are paid for the type or position of practice: rural practice payments; dispensing fees; designated area allowance; initial practice allowance; inducement allowance; and group practice allowance (three or more doctors).

Jones et al (1978) calculate the proportion of income that the 'average' general practitioner earns under each heading (for 1975/6)

Fixed sum	21%
Capitation	45%
Item of service	6%
GP qualifications	6%
Type or position of practice	12%

The remaining 10 per cent was, they suggest, made up by reimbursements and minor items.

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1 The Vocational Training Scheme (VTS), which became mandatory in August 1982, is required for all intending principals in general practice. The regulations require two years post-registration hospital experience, in approved posts (four out of obs/gynae, paediatrics, geriatrics, psychiatry, A & E, medicine) and one year full time or two years part time as a trainee with a GP teacher (Women in Medicine, 1982:12).

While the above is NHS income, GPs can earn income in a variety of other ways, outside the health service. These include performing such work as insurance examinations and reports; other medical examinations and certificates (e.g. for HGV licence, medical examinations); legal reports; cremation fees. Most GPs carry out some or all of the above at times. Other sources of private income include appointments with local authorities; medical officers to schools; industrial medical officers; hospital appointments (Hospital Practitioner Grade); appointments to other bodies (e.g. Post Office); teaching and lecturing; and, of course, private patients.

From the above it is apparent that general practice is a business and a complex one at that - and this becomes even more apparent when consideration of practice expenses is taken. Many of the costs of general practice are not related to list size. In fact the Acheson Report (1981) suggests that capitation fees for the 'average' GP account for less than half the total practice income (as was suggested by Jones et al (1978) and referred to above). Acheson (1981) also claims that high marginal tax rates result in there being little incentive to take on extra patients. Provided a doctor has a list of at least 1000 patients there is no great incentive to build up list size or concentrate efforts on NHS practice, since all available benefits are payable at this level provided private practice does not account for more than 10 per cent of total income (Acheson Report, 1981).

Describing general practice as a business implies a 'business ethos', whereby it pays doctors to 'manage' their practices so that they maximise their financial rewards (for example, by not taking on extra patients where it is not financially in their interests to do so). This inevitably has some impact

on the overall doctor-patient relationship and can be seen to stem fundamentally from the 'independent contractor' status of general practitioners. Such a status implies the need for GPs to build their income with care, and to be consistently aware of ways of maximising income. This may or may not be to the detriment of the patient, or the staff within the practice. The introduction of the NHS in 1948 was supposed to overcome the inequalities of health care between different sorts of patients, i.e. 'panel' patients compared with paying patients, but the present remuneration system perpetuates many of the problems of the pre-NHS way of working. Jones et al (1978) show that there are many ways in which GPs do not claim their full entitlement, and implore doctors to make this aspect of managing their practices paramount. They:

> believe that many general practitioners .... do not claim in full the expenses to which they are entitled. This affects not only the amount of tax which those general practitioners themselves pay, but also diminishes the expense factor - and therefore the income that all general practitioners receive. (1978:23).

The stress on the importance of maximising practice and personal income, as opposed to patient welfare, seems to be the antithesis of what the NHS was meant to achieve for practitioners and patients. It is to some extent perpetuated by GPs' independent contractor status, which they have always been loath to relinquish, since they view the present arrangements as the only way they can keep control professionally.[2]

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2 See Appendix E for fuller consideration of the system of payment for general practitioners, taken from Primary Health Care: An Agenda for Discussion, HMSO, Cmnd. 977 (1986:56).

3.2 The Medical Practices Committee

The next aspect of general practice considered is the Medical Practices Committee which occupies a key position in controlling the nature and distribution of general practices throughout England and Wales. This Committee was first constituted under Section 34 of the National Health Service Act 1946. The original provisions regarding constitution were subsequently consolidated under Section 7 of the NHS Act 1977. It is a statutory body appointed by the Secretary of State, and its principal function is to control the distribution of GPs in England and Wales. (There is a separate MPC for Scotland, and Northern Ireland has different arrangements) (Whowell, 1981).[3]

The MPC exercises its function of controlling the distribution of GPs in England and Wales by considering all applications for inclusion on the medical lists kept by the Family Practitioner Committee and by reviewing the need to fill practice vacancies. Its actual controls are negative ones: the MPC cannot tell doctors where to go, but it can tell them where they may not practise (Whowell 1981).

The need for practices is determined by the MPC through classifying areas as either "designated" (average list size $\geqslant$ 2501); "open" (list size 2101 -

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3 This function is governed by Sections 29 to 34 of the 1977 Act. The subsidiary function relating to prohibition of sale of medical practices and other relative transactions are exercised by the Committee under the terms of Section 54 and Schedule 10 of the 1977 Act. These statutory duties of the MPC are described in more detail in Parts 2 and 3 and Schedules 1 and 2 of the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 and the National Health Service (Vocational Training) Regulations 1979.

2500); "intermediate" (1701 - 2100); "restricted" ($\leqslant$ 1700). "Restricted" areas are closed to more GPs while "designated" ones require more GPs. The whole process is more delicate and refined than would appear from these crude indicators of list size; each case is decided individually, but these classifications give some idea of the criteria used for distributing GPs. (A more detailed exposition of MPC procedures is given in Whowell (1981) and the Acheson Report (1981:27-29). There are, however, some points specific to the appointment of single-handed general practices which are of interest for the present discussion.

While the MPC is ultimately responsible for appointing a doctor to a single-handed vacancy it delegates the initial consideration of applicants to the Family Practitioner Committee (FPC), which advertises the vacancy, short-lists candidates, interviews them and sends all the applications to the MPC with its recommendations on who to appoint. If the single-handed vacancy occurs in a health centre one of the doctors there usually attends the FPC interview to ensure compatibility. Occasionally the MPC will not accept the FPC's recommendation and will then invite a further short-list of candidates for interview at the MPC'S offices in London. The FPC and Local Medical Committee (LMC) will send representatives to attend.

Complications occur when a single-handed vacancy occurs in a 'restricted' or 'intermediate' area - the FPC has to ask the MPC for permission to advertise the vacancy. The MPC may decide either to disperse the practice or to stipulate that only doctors on the local list can apply.

The MPC has a policy of giving weight to length of experience in general practice in the UK, especially in the sort of practice that has become

vacant. Such a policy has been criticised where single-handed practices are concerned since the MPC is reluctant to appoint young doctors straight out of Vocational Training Schemes (VTS). The MPC considers that while inexperienced doctors may fill vacancies where there is a partner to guide them, they have less claim to take sole charge of a single-handed practice.[4] This is a less contentious issue now that the VTS is mandatory. Previously, doctors who had taken the initiative and given up the time to get this extra valuable qualification and experience were to some extent having it invalidated by the MPC requiring them to have another two years general practice experience on top. It is questionable whether two years general practice experience is more valuable than that obtained during the VTS (it could be argued that the introduction of the mandatory VTS demonstrates its undoubted validity over unstructured/unobserved or unassessed general practice experience). However, the MPC has now relaxed this stipulation and less than two years experience as a principal is in some cases considered sufficient for appointment to a single-handed vacancy.

Some single-handed GPs who wish to appoint their own successors try to get round the MPC rules and procedures for appointments described above by taking a partner and retiring shortly afterwards, in the hope that the new partner will be able to take over the practice.[5] The MPC will not normally accept one partner as successor to another who has died or

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4 Other professions similarly discourage or prohibit single-handed practice by newly qualified professionals (e.g. solicitors).

5 See Chapter 11 for an example of a GP who is attempting to do just that.

resigned if the partners have been together for less than a year. However, each case is decided on it's merits, and there are exceptions here as well. "The hallmark of the Committee's approach to individual cases is flexibility .... the MPC will bend the rules in every direction without ever breaking them." (Whowell, 1981:1486). The implications of these procedures for obtaining a single-handed practice will become evident when the interview data from this study are discussed.

3.3 The deputising services - out-of-hours cover

Out-of-hours cover is an aspect of general practice which constitutes a problem that has been gaining momentum in discussion over recent years, largely because of changing attitudes towards the nature of the professional career. The problem of out-of-hours cover for GPs is a pressing and controversial one, particularly for doctors practising on their own. The deputising services, which are used by many GPs to help them in providing cover for their patients out-of-hours, have been heavily criticised for a number of reasons. This section discusses the deputising services and the problem of out-of-hours cover in preparation for chapter 9, where the subject of out-of-hours cover is raised as a gender issue.

The growth in the use of the deputising services in recent years is a result of the continuing proportion of doctors not working in group practice and, certainly in the cities (in London particularly), choosing not to live in the area in which they work. The unwillingness of doctors to be 'on-call' in a changed social climate is also a major factor in the increased use of the deputising services (see chapter 9).

The Royal Commission on the NHS, in its discussion of deputising services, observed:

> Complaints most often made were that the deputy lacked personal knowledge of the patient and access to his medical records, that contacting the service could be difficult, that deputies were slow in responding to emergencies, and that the standard of some deputies was unsatisfactory (quoted in Acheson Report, 1981:29).

The Acheson Report suggests, though, that commentators like the members of the Royal Commission also acknowledge that "there are advantages in having a deputising service available, especially for GPs who work single-handed" (1981:29).

Studies which have looked in some detail at the use of deputising services tend to be in basic agreement about the extent of their use, and have shown that doctors in larger groups tend to make less use of the service than doctors in single-handed or two-person practices (Williams, Dixon and Knoweldon, 1973). Muckle (1973) in his report of working for a deputising agency for a period of 8 years, estimated that only in one-fifth (20 per cent) of instances did the patient feel that their own doctor should have been personally responsible for the visit. This indicates a high level of acceptance of deputising services amongst patients. Where there are patients who do not find deputising services acceptable, this may have arisen through some confusion between them and message handling services. Where GPs work single-handed and where GPs have little or no ancillary help, the majority of doctors make extensive use of message handling services, to take, hold and pass messages, and "it is often this apparent barrier between patient and GP that gives rise to adverse comment" (Acheson Report, 1981:30).

Cartwright and Anderson (1981) show that despite an increase in partnerships and decrease in single-handed practices, the need for an outside deputising service to attend emergencies and night calls has not declined as would be expected. They suggest that in general it seemed that GPs using deputising services were less positive about their work than other doctors. Such GPs regarded a higher proportion of their consultations as trivial, inappropriate, or unnecessary, and were less likely to enjoy 'very much' their work as a GP. They gave a lower patient acceptance of the deputising service than did Muckle (1973), who also estimated that 80 per cent of visits were non-urgent (i.e. trivial, inappropriate or unnecessary as mentioned above). Despite recent criticisms of the commercial deputising services, Dixon and Williams in their study of 100,000 patient contacts with deputising services found "no substantial evidence of shortcomings in the care" (1977:42), although they did not assess patient opinion.

There are certain controls on the use of the deputising services, and the FPC has to grant consent for a GP to use them, and use is usually granted on a limited basis - to provide reasonable relief for the GP concerned. However, evidence suggests that usage is far more extensive - some practices having all out-of-hours cover provided by the deputising services (Acheson Report, 1981). This Report also pointed out that there is little information regarding the operation of deputising and answering services, sometimes leading to a confused and uncoordinated provision of services. As the Report says:

> This is not in the best interest of the public or of the majority of GPs who use the service properly. The lack of information which clouds possible abuses of the system reduces the effectiveness of the service available and scars relationships between GPs, the public and other service providers. (1981:31)

In his study of a doctor's deputising service in a single-handed practice carried out over a period of one year Naidoo (1982) concludes that there was little difference between the number of calls for the deputising service and cases where GPs covered their own out-of-hours calls. It would seem most likely that this is because most patients do not know whether their GP is on call or not at any particular time. Naidoo also found that young mothers with children under 5 were the most frequent users of the service - so that the age/sex structure of a practice list may well influence the number of out-of-hours calls rather than whether the deputising service is in use or not. Also, from the point of view of GPs, the most economical or cheapest time to use the deputising service is between 23.00 and 07.00 (Naidoo 1982).

While the Acheson Report (1981) shows that use of the deputising services is highest amongst single-handed and two-person practices, amongst single-handed practices use is also related to the age of GPs. So that in London and other inner cities (Bolden, 1981) where there are a relatively large number of elderly single-handed GPs, use is much higher. There has, however, been no attempt made to observe the effect of doctor's gender on deputising service usage. It seems likely that there could be a correlation between women GPs and higher use of deputising services, particularly for night calls.

With the recent criticisms of commercial deputising services and the call for NHS run services, consideration has not been made of the possibility of an increase in usage if an NHS scheme was introduced. More use may be made of an NHS run scheme since at present many GPs do not consider the use of commercial deputising services financially viable. This is

presumably another example of how GPs are concerned with putting financial considerations to the fore in the running of their practices (see section 3.1). The data concerning out-of-hours cover and use of deputising services in this study is considered in chapter 9.

3.4 Premises

One particular way in which the nature of general practice has changed in recent years is in the emphasis which is being placed on the nature of the premises from which the practice of medicine is generated. In many ways the quality of the premises is now viewed as an important indicator of the quality of the general practice facility overall. There are certain specifications required for GPs' premises, but since minimum stated standards are very limited, the condition of many existing premises is very poor. The Acheson Report (1981) sees one of the reasons for the comparatively large number of single-handed GPs in inner London as the difficulty of finding suitable practice premises for group practices with attached or employed community nursing staff. In London this is related to the high costs which poor quality premises still attract. While this problem occurs in other inner cities to some extent, this cost/poor quality relationship is nowhere as acute as in London.

The problem of suitable practice premises in inner London and elsewhere has been exacerbated by the lack of routine inspection of premises by FPCs until recently (although this is not the case throughout the country) many of whom have now instigated systems for the routine visiting of premises. Inner cities have many practices which are of the lock-up shop variety and which often lack the most basic amenities, such as toilets or running water,

even electricity! In fact, facilities such as a flushing toilet are not required if there are adequate public facilities nearby. The standards recommended as desirable features to be achieved in practice provision are set out in para 56 Schedule 1 of the Statement of Fees and Allowances (SFA) and it is estimated that only one quarter of premises in inner London come within these recommended standards (Acheson Report, 1981). However, the standards are recommended and not laid down. The status of the schedule is only one of advice, and GPs are not required to adhere to them. For example, they do not have to provide accommodation in their premises for other primary health care workers - and in London they rarely do so.

The idea of building health centres stems from the Dawson Report [6] and more recently the Doctors' Charter of 1965[7] and has inevitably meant some changes. Cartwright and Anderson (1981) suggest that between 1964 and 1977 the increase in health centres was one of the most dramatic changes in general practice. The number of GPs practising in health centres rose from 215 in 1965 to about 3800 in 1977, working in 28 health centres in

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6 The Dawson Report (1920) on the future of medical and allied services favoured the concept of group practices operating out of health centres.

7 The Doctors Charter came as a result of considerable unrest on the part of general practitioners over the status of GPs in comparison with hospital consultants, arising from the system of remuneration in general practice. General practitioners threatened to withdraw from the NHS in 1965 in response to what they saw as the government's inaction regarding their case. The threat of mass resignations from the NHS brought the government into direct negotiations with the profession over the Charter, resulting in a contract which included some, but not all, of its demands. The new contract which emerged forms the basis of the present structure of general practice. Most significant in the present context was the establishment of financial incentives for group practices.

1965 compared with 731 in 1977. Bowling (1981) has also demonstrated the considerable movement towards group practice between the early 1950s and the early 1970s; in 1951, 80 per cent of GPs practised single-handedly, whilst by 1971, 80 per cent practised in partnerships of two or more. While the significance of these increases is considerable for all aspects of general practice, in the present context it had a positive impact on the quality of practice premises. In joining health centres, many GPs combine into bigger groups, but single-handed GPs may also practise within health centres. Health centres, being purpose-built, mean that facilities are good on the whole. There are greater possibilities for single-handed GPs to share certain facilities and staff. Cartwright and Anderson (1981) look in some detail at health centres and patterns of work within them. One important aspect of their study concerned the financial side of health centres. On the one hand, there was reduced financial cost in that there was no initial capital expenditure on furniture, fittings etc; and there was shared costs for new equipment; but on the other hand there was high and increased running costs, and difficulty in regulating and controlling costs. Another finding of the study was that in health centres there are better facilities. For example, there is better equipment and economies of scale. All services are available under one roof with more space in a modern, purpose-built building, which is more comfortable for the patients. Conversely, however, there could be loss of professional independence for the doctor, with no security of tenure, and added problems of not owning the building with the possibility of eviction. Other criticisms of premises included the loss of a homely atmosphere, and the problems for patients of travelling to centralized surgeries, when the health centre may not be as conveniently situated as the old GP surgery.

The Acheson Report (1981) highlighted the extent of poor quality practices where no or a minimal amount of adaptation had been made, or where premises and facilities were very outdated, and Bolden (1981) similarly discussed the problems of premises in his study of general practice in inner cities. He looked at nine large cities and found that the worst problems exist in London, Liverpool and Glasgow. There is particular difficulty in obtaining suitable premises, either because property is so expensive to buy and repair or because sufficient land or alternative accommodation is not being offered by the authorities. Added to this is the problem of rising vandalism and practising from sub-standard premises - often of the lock-up type - which have never been improved despite financial opportunities to do so from the General Practice Finance Corporation.[8]

Jefferys and Sachs (1983) suggest that a majority of patients prefer health centre premises over older premises. Although there were some criticisms, these were a minority of opinion. Other studies corroborate this finding (Bolden and Morgan, 1975). Drury (1979) shows that for privately owned premises 57 per cent of loans have been taken up by single-handed general practitioners and such loans have entailed larger sums per doctor e.g. in 1974 the average sum borrowed by a single-handed doctor was around £9,000 compared with the figure of £6,000 for each member of a partnership.

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8 The General Practice Finance Corporation administers loans to GPs for buying and updating practice premises.

The question of the premises a doctor uses are important when discussing a number of issues where single-handed doctors are concerned. For example, the condition of the premises and facilities offered within them is important for all GPs, but the question of what they can offer for ancillary staff and the primary health care team is becoming critical, and something which single-handed GPs find can undermine their status, independence and the way they run their practices. The premises also have implications for the doctor-patient relationship: for example, whether the surgery is attached to the doctor s home, is of the lock-up shop variety, or situated in a health centre. Of course, these aspects of general practice premises all have implications where financial considerations are concerned - as Drury (1979) has shown, single-handed GPs need considerably more financial assistance than GPs in groups in setting up and running a practice. These issues arise at different points throughout the thesis (e.g. see chapters 5 and 8).

3.5 The development of group practice[9]

The way in which general practice has developed from an essentially 'individual' into a more 'collective' activity in the last twenty years or so is crucial for an understanding of single-handed general practice. The discussion of possible changes to the traditional family doctor method of practising (discussed in Chapter 1) and the discouragement of single-handed

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9 In the discussion which follows, a 'partnership' refers to two or more doctors practising together and a 'group' to three or more doctors practising together. The terms are thus largely interchangeable.

practice goes back many years. As long ago as 1920 the Dawson Report favoured the concept of group practices operating out of health centres and this idea has been followed by a number of other committees and advisory groups subsequently, who have argued the case against single-handed practice. The case against single-handed practice has stressed such issues as the advantages of peer influence and informal learning within groups to raise the standard of care, and hence the status of the general practitioner, leading to more satisfaction in their work. In addition, financial arguments have been advanced, concerning the ability of group practice to provide better premises and equipment and more ancillary help. A more varied professional life is possible too, it has been claimed, since more opportunities exist for GPs to hold outside appointments, with the greater flexibility which becomes possible in the management of time. And group practice, it has been suggested, provides a more realistic method of organisation for the development of primary health care teams (Bowling, 1981). In effect there has been an increasing weight of argument positively to promote group practice as beneficial for both doctors and patients, while single-handed practice has been negatively assessed as out-moded and detrimental to both.

The watershed in the change from the great majority of doctors practising single-handed to a majority practising in groups and partnerships of (whatever size) seems to have been the 'Doctors' Charter' of 1965 (Fry, 1979)[10]. The Charter resulted in a contract which forms the basis of the present structure of general practice. The contract consisted of a basic

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10 See section 3.4 for an explanation of the Doctors' Charter.

payment available at the full rate to doctors with at least 1,000 patients who provided full services for a minimum period in each week, available at proportionally reduced rates to other doctors. Additional payments were made in respect of group practice and practice in deprived areas. There were distinction awards depending on doctors' attendance at postgraduate training courses. There were additional services remunerated on an item of service basis, capitation fees with an age allowance for patients over sixty-five of 30 per cent higher than for other patients, and night and weekend work were remunerated as were home visits between midnight and 7am. Six weeks' paid holiday and a notional five and a half day week were established, on condition that doctors arranged for patient care in their absence (Bowling, 1981).

Most significant in the present context was the establishment of financial incentives for group practices. The movement towards group practice between the early 1950s and the early 1970s was very considerable; in 1951, 80 per cent of GPs practised single-handedly whilst by 1971, 80 per cent practised in partnerships of two or more. This figure has remained more or less stable since the early 1970s and a large proportion of the doctors who do not work single-handedly still practise in small groups or partnerships. Bowling (1981) has suggested that this could possibly be because the concept of group practice and the primary health care team are anathema to the traditional notion of independence still respected by many doctors. She states

> .... the image of the general practitioner as totally independent, practising in isolation from other doctors and other health workers, cannot survive if group practice and health centres are to become the standard pattern of medical practices.
>
> (Bowling, 1981:24)

Sidel, Jefferys and Mansfield (1972) indicated that some doctors **would** dislike working in teams, in their study of general practice in the London Borough of Camden, but point out that general practice cannot be organised around the psychological needs of individuals who may perform best when practising alone.

In their study of general practice, Cartwright and Anderson (1981) looked at doctors' and patients' perspectives of partnerships/groups and single-handed practice, and compared these with Cartwright's earlier study published in 1967. Their findings are particularly interesting in relation to debates about size of practice and the advantages and disadvantages embodied in partnership size. They concluded that: 'people's relationships with and opinions about their doctor vary remarkably little with the number of doctors in their practice' (Cartwright and Anderson, 1981: 17).

The authors picked out a number of ways in which practising single-handedly or in partnerships affect the quality of practice and of life for both doctors and patients. For example, doctors in partnerships are on call at night less than those working single-handedly, have more ancillary help, better facilities, and carry out more procedures themselves. Single-handed GPs rarely take GP trainees into their practices for a period of training under the Vocational Training Scheme. Despite these differences the study suggested that there seems to be little relationship between GPs' enjoyment of their practice and whether or not they practise single-handedly or in partnership. There was, however, somewhat more frustration experienced in practising in partnership, but no differences in frustration levels caused by lack of leisure or free time. Of significance

was the fact that satisfaction with the care given to patients increased with the length of time patients had been with their doctor, and not with the size of practice partnership.

In summing up the findings of their comparison between single-handed GPs and those in partnerships, Cartwright and Anderson suggested that the decline in single-handed practice and increase in partnerships with three or more doctors appears to have had little effect on the nature of general practitioner care or on patient-doctor relationships (1981: 40). Changes in the organisation of general practice since the 1967 study were considerable, while those in the basic relationship between patients and doctors were small and mainly insignificant.

Such findings are interesting if one considers the reasons behind the initial impetus and subsequent moves towards partnerships and away from single-handed practice. They suggest that the advantages claimed for partnerships and group practices may have been over-stated. This study similarly shows some of the benefits of single-handed practice as far as GPs (and, in particular, women doctors) are concerned, when compared with the experiences of working in groups.

3.6 The Doctors' Retainer Scheme

The Doctors' Retainer Scheme was perhaps one of the first moves within medicine which sought both to establish equal opportunities for women and to reduce what was viewed as an unacceptable 'wastage' of women doctors. The Scheme was primarily designed to encourage those with family responsibilities to keep up-to-date with medicine. It was originally

conceived of as the Women Doctors' Retainer Scheme but changed its name when it become open to men too (see chapter 2).

A doctor joining the scheme agrees:

(1) to maintain registration with the GMC and membership of a medical defence organisation (or other suitable insurance);

(2) to attend at least 7 education sessions a year, which can be arranged to fit in with family responsibilities;

(3) to take a professional journal;

(4) to work at least one half day a month and be ready to take on more work, up to a maximum of one day a week, if asked to do so, providing this does not interfere with family commitments.

> The Doctors Retainer Scheme is for doctors under 55 who are currently not working more than one day a week and who wish to remain in touch with medicine so that they can return to the NHS when their circumstances permit. They have the opportunity to do a small amount of specially arranged paid professional work and to attend postgraduate medical education sessions and they receive a retainer (£155 in 1982) to help meet their expenses. (Doctors' Retainer Scheme Leaflet, 1977).

The DHSS discontinued the collection of data on the numbers of women doctors not practising in 1980. The latest data available are from 30 September 1980 of women doctors in England and Wales shown in Table 3.1.

Table 3.1 Numbers of active and inactive women doctors in England and Wales, 30 September, 1980

	All ages total	Under 30	Age 30-39	40-49	50-59	60-69	70 & over
not active (including retired)	2964	123	131	113	199	631	1767
Active	18281	4801	5266	3610	3285	1197	122

Source: Medical Women's Federation

Such data do not give any indication as to why doctors are inactive and one can only surmise that this is related to child care, difficulty of finding part-time work, part-time training, or a need to follow husband's location and so on. If one takes the figures of inactive women doctors under retiring age (i.e. 2964-1767) this gives 1197 inactive women doctors under retiring age. This means that for every 15 active women doctors, there is one expensively trained inactive woman doctor.[11] However, this gives no indication as to how long they are inactive.

In England and Wales the number of women doctors using the Retainer Scheme on 30 September 1982 was 323 (plus about another 100 in Scotland). This figure does not differentiate between types of practice, so that it is not possible to know how many are in general practice. Despite considerable optimism in respect of the Doctors' Retainer Scheme at its commencement in 1972 (Lancet, 1972) it has been poorly taken up. Beaumont (1978) found that 25 per cent of doctors in her study had not

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11 The figures 15:1 are arrived at as follows:
Active women doctors under 70 are 18281 - 122 = 18159
$\frac{\text{Active women doctors}}{\text{Inactive women doctors}} = \frac{18159}{1197} = 15$

even heard of it (a larger proportion of doctors in this study had never heard of it), and many criticised it, reporting difficulty in obtaining a place, but there are substantial regional variations in the implementation of the Scheme. Many doctors make minimal part-time working arrangements, or participate in part-time training in preference to the Retainer Scheme. Much of the literature criticises the lack of provision and opportunity for part-time working and training, particularly in certain specialities and at higher grades, especially consultant grades (see chapter 2).

3.7 The Acheson Report - on retirement

A discussion of retirement brings the changing context of general practice up to date, because the encouragement of retirement has been viewed, in a recent report, as a crucial element in bringing about an improvement in the quality of general practice. One of the important areas of recommendations made by the Acheson Report (1981) concerned the issue of retirement for general practitioners. The Report identified a high proportion of elderly single-handed (male) GPs working in inner London, and the age of single-handed GPs in inner London was a critical factor in its criticism of single-handed general practice as a whole. These data are presented in Tables 3.2 and 3.3.

Table 3.2

Age distribution of GPs in London and elsewhere: 1979

	60-64	65+	65-69	70+
Inner London	10%	18%	8%	10%
Outer London	9%	11%	5%	6%
England & Wales	7%	6%	3%	3%

Table 3.3

Age distribution of GPs aged over 70 working in inner London

Age at 1.10.79	No of GPs	%
70-4	52	49
75-9	33	31
80-4	15	14
85-9	5	5
90+	1	1
Total	106	100%

The Acheson Report suggests a number of reasons for the high level of elderly doctors practising in inner London, as a result of a questionnaire survey. Reasons given for continuing in NHS practice were:

(1) unable to afford to retire owing to insufficient pension/capital 57%

(2) unable to forego rent and rate reimbursement on surgery/home 15%

(3) reluctance to sever links with NHS general practice 89%

The Report goes, on in explanation, that there is no financial incentive for GPs to retire and stop working. Notional retirement, whereby a doctor can retire at any time after the age of 60, and immediately resume work is criticised.[12] Both Acheson and the 1986 Green Paper Primary Health

12 Notional retirement qualifies a doctor for payment of superannuation in addition to remuneration for NHS work. If he opts for "notional retirement" before the age of 65, his pension is abated until age 70 so as to maintain total income at the previous average level of earnings. This acts as a positive disincentive to accept new patients or even to maintain his existing list as extra patients mean work but no extra money. The GP is able to reduce his workload - i.e. the number of patients on his list - while maintaining a constant income. If he notionally retires after reaching 65 the abatement rule no longer applies. The GP receives full pension and full remuneration.

Care: An Agenda for Discussion recommend an end to notional retirement. However, because of the ready availability of deputising and relief services in inner London, elderly GPs can continue working on a limited scale more easily than their counterparts elsewhere in the country.

As stated, one of the main recommendations of the Acheson Report was "... the introduction of a retirement policy to encourage many older doctors in central London to retire" (Acheson 1981:37). The suggestion is that there should be retirement at age 70, which would enable the creation of about 40 vacancies in inner London straight away and certainly increase the 1981 figure of 9 retirements a year of GPs over 70 throughout the whole of inner London. This would both create new vacancies for young doctors and keep general practice medicine up to date. The Report recognises that a retirement policy runs counter to long-established traditions in the independent contractor services, but sees it as a necessary requirement (despite one dissenter on the committee). It recommends that retirement should apply only to principals.

The effects of a retirement policy would be considerable on a national scale as well as in inner London. It was estimated in the Report that this would involve 800 doctors nationally with immediate effect and a further 1000, over the following 5 years. As well as the effect on the availability of vacancies for younger doctors, there is also discussion on the financial implications on implementation of a retirement policy. Recommendations

are made, therefore, that arrangements should be made to ensure that those doctors who retire should not suffer financial hardship as a consequence, and that suitable compensatory arrangements should be made by the DHSS.[13]

It is also implied by the Acheson Report that a retirement policy would have some effect in decreasing the number of single-handed practices which is seen as desirable.[14]

An understanding of the implications of a policy of retirement at age 70 is important for understanding the position of GPs in general. However, retirement is seen also as a way of reducing the number of single-handed GPs, so this issue is directly related to this study. It certainly has some consequences for how single-handed GPs see and plan their future, as can be seen in chapter 11.

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13 It should be noted that it has taken until 1986 for the discussion provoked by the Acheson Report on the issue of retirement of GPs at age 70 to be taken up in the form of Government policy (see Primary Health Care: An Agenda for Discussion, 1986). Such recommendations are still being rejected by the profession itself.

14 In this study there were no doctors over the age of 70, but four women were aged between 60 and 70 and could possibly have taken notional retirement. It appears, therefore, that a retirement age of 70 would not have affected any of the sample at the time of interview, although some were approaching retirement age. This is because single-handed women GPs are proportionally younger than single-handed men GPs (see chapter 11). A retirement policy would therefore have no effect for some years on the number of single-handed practices run by women from this study.

3.8 1986 Green Paper - Primary Health Care: An Agenda for Discussion

It is appropriate to conclude this review of aspects of general practice by referring to the latest official thinking on this matter which continues to undergo discussion in different sectors of the health professions. The Government Green Paper Primary Health Care: An Agenda for Discussion (H.M.S.O. Cmnd 977, 1986) was presented to Parliament in April 1986 and deals primarily with those services which are contracted under the FPC. Its recommendations on General Medical services (i.e. those services provided by GPs) take on board many of those first published in the Acheson Report (1981), as well as some new ones. And in the context of single-handed practice there are some important recommendations.

For example, the document recommends the introduction of a 'good practice allowance'. Entitlement to a good practice allowance would be linked to several factors, amongst which is included:

> personal availability to patients, both for surgery consultation and in terms of out-of-hours cover (1986:14).

The issue of 'personal availability' to patients in terms of out-of-hours cover is a thorny one, and particularly important for single-handed GPs to come to terms with. In chapter 9 this aspect of GP care is discussed as both a gender issue and as one for single-handed GPs. However, the Government Green Paper equates 'personal availability' with 'quality' in general practice, an equation which is challenged in terms of realistic general practice in this study. There are all sorts of ways in which single-handed GPs may be providing a 'quality' service for their patients which

because of the definition of 'quality' used in the Green Paper would specifically exclude single-handed GPs, (and even more specifically, women) from qualifying for any 'good practice allowance' which may be forthcoming. In fact, another entitlement to a good practice allowance relates to "attendance at recognised postgraduate education courses", (1986:15) is often difficult for doctors working alone to organise because cover for patients has to be arranged during any time the doctor may not be readily available. It was certainly a factor in this study (see chapter 11) that attendance at postgraduate sessions proved difficult. In addition, other factors which are seen in the Green Paper as "indicative of high quality work" (1986:15) - such as GPs acting as GP trainers - are less likely to be activities which a single-handed GP carries out. (For example, few single-handed GPs act as trainers because one of the qualifications for acting as such is the size of the practice list, with a number of patients which many single-handed GPs cannot aspire to - there were no GP trainers in this study, and only two had ever considered trying it).

The issue of compulsory retirement at age 70 has an indirect impact on single-handed practice too, as seen in section 3.7 above. The Government intends to introduce retirement at this age; this must be a positive factor in making room for the young vocationally trained GPs who are looking for practices. It could have a positive impact on the image of single-handed GPs, since one of the basic criticisms of GPs practising alone is that they tend to be elderly and past normal retirement age. It could tentatively be suggested that should such a policy of retirement be implemented, then after the initial rush of retirements of elderly single-handed GPs there would be a stabilising effect on this way of practising. Possibly a new image of single-handed practice would be generated by more younger GPs

being able to experience the positive aspects of this way of practising (see the discussion in chapter 7).

These were the main recommendations of the Government Green Paper where they relate directly or indirectly to single-handed general practice. As stated initially, this chapter has considered some aspects of general practice structure and changes within it which relate to single-handed practice and has provided a background and context against which subsequent discussion can take place.

CHAPTER FOUR

METHODOLOGY:

A PERSONAL ACCOUNT OF RESEARCH

A number of edited accounts of sociological research (Bell and Newby, 1977; Bell and Encel, 1978; Roberts, 1981 c , Bell and Roberts, 1984) have shown the importance of exposing the research process to scrutiny. They suggest that research writings are often presented in a manner which both 'cleans up' and 'sanitises' the essential messiness of the research process, which consequently hides the actual 'truth' of the research situation and analysis. As Roberts has suggested in the introduction to her edited collection:

> (This volume) proceeds from the basis that problems raised in personal accounts of research are themselves of sociological importance and that such accounts can offer the student a lively insight into research of a kind that is often denied by conventional methods textbooks (1981 c : 1)

In the same way, this chapter presents a personal account of the research methods used in this study. The idea of focussing on the dynamics of the research process has evolved from, in effect, and developed the Glaser and Strauss (1968) thesis on 'grounded theory'[1]. I shall explore this

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1 Glaser and Strauss' 'grounded theory' derives from the philosophy of Kant and phenomenology and exemplifies the 'interpretive' tradition in sociology. It sees research as a two way process which moves continuously from theory to data and back from data to theory. Theory is seen as a process: an ever-developing entity, not a perfected product. At each stage of the research, data are produced which throw light on the original research problem and help to guide the next stage. Data collection, then, is controlled by the emerging theory, and collection of further data cannot be planned in advance of the emerging theory.

development, then relate this study and my own evolution as both researcher and person to that research process using a feminist perspective, and use the idea of a 'reflexive' sociology (Roberts, 1981a).

4.1 The developing research

The history of any research study is a personal one and I shall begin by explaining the basis of the choice of single-handed women GPs to explore the influence of gender in society. The three year SSRC (later ESRC) studentship which I was awarded in 1981 was 'linked' to a study of women lawyers. The idea of the 'linked' studentship was to enable the inexperienced researcher to have the support of, and be involved in, research in a related area. It was hoped that the 'linked' research would benefit from the ongoing research which would also provide a forum for learning about and practising the research process. The intention for the studentship was that it would complement the 'women lawyers' study by looking at women in another profession. My immediate response was to decide to look at women doctors because of the influence of the 'medical' in my past experience. This medical experience has comprised nursing, working as a medical secretary and as a research assistant on a dental health project. I had, therefore, over a number of years been thoroughly inculcated into the medical ethos from a number of different standpoints.

The choice of women doctors as a field of study was consequently a natural one. In addition, my own experience of working in hospitals (and a considerable history as a patient too) told me that women doctors had been

almost totally invisible. Medicine appeared to me to be male-dominated, though I was aware of a female presence in general practice. I had been registered with two women GPs out of four in my life and this suggested to me that that was where the typical woman doctor would be found. I settled, therefore, on the idea of looking at women GPs. This decision was influenced by the 'women lawyers' project, too. If there was to be a 'linked' element between the two pieces of research, then general practice seemed to be more directly comparable to the legal profession (which is mainly organised in small groups in both barristers' chambers and solicitors' practices) than did hospital medicine. Finally, I felt that within medicine generally the trend away from hospital-centred care (Davies, 1979) into the community meant that there was a need for greater understanding of primary health care and general practice.

The decision to study women GPs having been made, the next decision was on which aspect to focus the research. Initial reading of the relevant literature led me in a series of different directions and I settled on several possible projects, my ideas changing almost daily.

In the meantime I was being incorporated into the 'women lawyers' project. When I took up my studentship, the project was at an advanced stage, with only a few months of funding left to run. A sample of women lawyers had been interviewed and a comparative sample of men lawyers was in the process of being contacted.

My incorporation into the 'women lawyers' project occurred in a number of ways. For the first six months of my studentship I shared an office with the woman researcher on the project. This was helpful both socially (we

became firm friends) and academically. She proved to be a good sounding board for my developing ideas on possible projects on women doctors. In addition, I was able to discuss issues relating to the relevant literature in my initial early reading informally and as they arose. I was able to listen to some of the tapes from the interviews with the women lawyers and to read the transcripts of the tapes too.

The next step was to view and take part in the interviewing process. I sat in on some interviews with men lawyers conducted by the project researcher and went out and did a large number (over 30) of the interviews with the men lawyers myself. This was particularly valuable in terms of both interviewing practice and my own subsequent research design. I was able on the basis of this experience both to take on various aspects of the interview procedure but, equally, to reject some aspects of it.

The interview schedule used on the lawyers project was semi-structured: the first half collected quantifiable data about background and experience, while the second half asked open-ended questions about the professional work and home lives of the lawyers, as well as their opinions on a number of related issues. The second half of the interview schedule was tape-recorded.

The women lawyers project thus directly influenced both the choice and design of my study of women GPs, as well as acting as an important learning experience. In this learning capacity the 'grounded theory' approach to research was already influencing the shape and style of the women GPs study. I was learning about women in another profession (the law) and automatically transferring that knowledge to my understanding of

the situation for women GPs. In addition, I was using this knowledge to help in designing the shape my study would take and developing a protocol for interviewing the women GPs.

By this stage I had the tentative idea of looking at general practices which comprised 'women only' practising in groups together. However, initial enquiries with the Birmingham Family Practitioner Committee revealed that there was only one such practice at the time. In providing me with a list of women GPs in Birmingham they marked off the 'women only' practices, which (with this one exception) were in effect those who practised single-handed. In comparing this figure with the number of single-handed men GPs, I found that the proportion of women practising single-handed was greater as a proportion of all women GPs in Birmingham than were the single-handed men as a proportion of men GPs.[2] I found these proportions of single-handed practitioners surprising since there was a general view that GPs should be encouraged to practise in groups as far as possible (Acheson, 1981). The tendency for a higher proportion of women than men to practise 'on their own' was particularly intriguing. I hypothesised that a study of single-handed women GPs would be very valuable. I would be able to examine the life of a woman professional who was under maximum pressure in her professional life, because of her 24 hour ultimate sole responsibility for her practice and patients. In this way,

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2 In 1981 single-handed GPs made up 14.7 per cent of GPs nationally. In London, this figure was 34.4 per cent and in Birmingham 22 per cent. Of the 22 per cent of single-handed GPs in Birmingham, 20 per cent were women, but 8 per cent of GPs overall in Birmingham were women (as against 18 per cent nationally - 1986 figure). (Data derived from Bolden (1981) and Birmingham Family Practitioner Committee).

the problems of both professional life and the reconciling of professional and domestic lives of the professional woman would be most clearly in evidence. Therefore, a project on single-handed women GPs would give me the most extreme and the most varieties of responses to being a women professional. I decided to proceed in this direction.

My aim was to show where gender was a significant issue in respect of the choices and decisions made in the lives and careers of women professionals, in this case in the lives and careers of single-handed women GPs. My immediate reaction, with the experience of interviewing men lawyers for the 'women lawyers' project in mind, was to reject any notion of a gender comparison in the study. However, I felt that it was appropriate to start with the women and make a final decision about interviewing men GPs once the project was under way, in much the way that this had occurred with the 'women lawyers' project.[3] I felt that employing the same criteria for women and men was not wholly successful with the men lawyers, and seemed inappropriate in the case of the objectives of the women GPs.[4] Working on the 'women lawyers' project had therefore led me first of all to reject the notion of interviewing men GPs. I still viewed my project as to some extent complementary to the 'women lawyers' study, however. The involvement with interviewing on the 'women lawyers' project had also led me to reject certain aspects of the research approach, too, and this point is now considered.

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3 The 'women lawyers' project had initially intended to interview only women lawyers, but further funding was obtained on the basis of making it into a comparative study.

4 i.e. to show where gender was a significant issue in respect of the choices and decisions made in the lives and careers of single-handed women GPs.

The potential numbers of single-handed women GPs that I would be interviewing was small. In order to collect data of a quantifiable nature I would have had to conduct a national study of these women. As a research student, with limited resources and time, this would have proved unmanageable. In addition I found that the sort of information I was seeking on the women doctors was comparable with the less structured part of the women lawyers interview. In the 'women lawyers' project the tape-recorded second half of the interview had elicited information of a qualitative kind, from which the nuances and perceptions of the respondents could be gauged. It seemed that a similar approach was suitable for my project and I was becoming progressively more attracted to the idea of allowing the women GPs to shape the essence of the research, rather than having any preformed ideas about what their responses and perceptions might be. I do not think I was wholly successful in this, partly because of myself and partly because of the women GPs themselves. However, I will explore that issue later.

I was also attracted to the idea of tape-recording the interviews, since I had found in interviewing on the 'women lawyers' project that this allowed the greatest flexibility in data collection.[5] In effect, I would not have to make final decisions about how I was going to deal with the collected data and methods of analysis until after the interviews had been collected. Many studies had shown the value of taped interviews for qualitative data

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5 i.e. that it allowed much greater interaction between interviewer and respondent and least distraction from concentration on the discussion than other methods.

collection and I was convinced of this value. It was also ideally suited to the relatively small number of women GPs that I would be interviewing, since large numbers of transcriptions are time consuming and expensive to transcribe and difficult to analyse. I decided to keep the study based reasonably locally and settled on 'the Midlands' for my study location. Being a Londoner, very recently arrived in Birmingham, my knowledge of what constitutes 'the Midlands' was elastic. The area I have included under this guise could possible be challenged; for instance women GPs from Sheffield were included but those from Oxford were not. In any case, by contacting the Family Practitioner Committees of the area which constituted 'the Midlands' as I had interpreted it, I was able to collect a sample from the whole of the area of 43 single-handed women GPs.[6] I knew, of course, that I could not expect to get 100 per cent participation from the women GPs, but felt that if I could get 25 to 30 to agree to be interviewed, this would give me a feasible number of GPs to work with and a manageable amount of data to analyse in depth. In the event, 29 of the GPs participated, two out of every three approached, which I judged to be a satisfactory sample of respondents.

My previous research experience, involving the use of self-completion questionnaires,[7] had confirmed the importance of 'piloting' in order that

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6 The sample of 43 single-handed women GPs were made up as follows: Birmingham - 18, Nottinghamshire - 10, Staffordshire - 4, Leicestershire - 4, Sheffield - 3, Derbyshire - 2, Worcester - 1 and Coventry - 1. Gloucestershire, Shropshire, Northamptonshire and Lincolnshire had none.

7 I worked as Research Assistant in the Experimental Dental Care Project 1973-1977 at the London Hospital Medical College, where questionnaires were used to elicit attitudes to dental care.

questions could be tried out and so that they could be modified to make the final questionnaire workable. I was also attending, during the first year of my studentship, a weekly research methods seminar where other research students were talking of testing and piloting and so on in their own research. My inclination, therefore, was to carry out 'pilot' interviews in my research.

I decided that in following the unstructured approach to qualitative research I should take this as far as I could, by having only a list of key words, which would remind me of topic areas for discussion, leaving the options for covering other issues open, as they arose in the course of an interview. In the style of 'grounded theory' I could, therefore, add issues that had come up in previous interviews and reject others which did not seem to be adding anything further to the data as they were collected. This 'grounded theory' approach thus makes the process of interviewing and analysis living and interlinked. Theory and practice are evolving in the course of the research with each interview throwing up data which influences the shape of the next. However, I had not understood the significance which 'grounded theory' would have in my research at the planning stage. Consequently, I did not realise that the six 'pilot' interviews which I conducted were integral to the whole body of the research and analysis. My 'pilot' interviews were not in fact testing particular questions and the whole interviewing structure (since structure was minimal), but rather setting the evolutionary nature of unstructured interviewing going. There is no question that the six 'pilot' interviews helped me develop my key words and topics. These continued to develop throughout the interviewing process and I feel now that these interviews were an integral part of the whole process of the research and part of the 'grounded theory' elicited by this study.

The six 'pilot' interviews can be divided into two groups of three. They were women doctors generally chosen in order to get a feel for the broader aspects of the research topic. The first group was derived from informal contacts: P1 was an ex-flat mate of mine who worked in community health; P2 was a women GP who worked part-time in a group practice and who I knew socially; P3 was my own GP who was in partnership with her husband. The second group of three were all single-handed women GPs from outside the area, i.e. outside 'the Midlands', P4, P5, and P6. Although the chapters which follow this one use the interviews conducted with the 29 single-handed women GPs of the main sample, the six 'pilot' interviews were strategic in the whole 'grounded theory' process, so that doctor 1 of the 29 was in effect the seventh of 35 interviews and should be viewed as such when considering the full analysis. There have, in fact, been places in ensuing chapters where the 'pilot' interviews have been used to help the analysis, since they were illustrative of certain areas of discussion which had not occurred in later interviews.[8] This is a perfectly legitimate use of the interviews in qualitative research when it is accepted that everything which is said is of value and potentially part of the analysis.

Once the six 'pilot' interviews had been completed, the 43 single-handed women GPs in the Midlands were written to asking them to participate.[9] This was done over a period of several months so that the interviews could be staggered. As indicated earlier the response rate was good in that 29 of

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8 One such example can be seen in chapter 10.

9 This letter is included as Appendix A.

the 43 single-handed women GPs agreed to participate in the study.[10] The letter inviting them to participate was followed up a few days later by a telephone call, except for three cases where the GPs wrote agreeing to take part and two GPs who wrote to say they would not participate. The reasons for not participating were generally "too busy", "lack of time", "not interested" and so on. There were a few cases where it was not possible to actually speak with the doctor herself because of the protectiveness of the receptionist. It did seem that by speaking to the doctor personally, I was in some cases able to persuade a previously doubtful doctor to agree to see me. Therefore, I had to be persistent with some receptionists and this paid off in a few cases, although in others it did not.[11]

How representative were the women interviewed of single-handed women GPs generally? This is the question which haunts all researchers who use samples of respondents. There is no data base against which to check the representativeness of those interviewed, but some general observations can be made. Eleven of the 29 were Asian, but it is not possible to know to what extent this may or may not overstate the proportion of single-handed women doctors from that background. The age-distribution of the women is indicated at Table 6.1. This distribution does not seem to be 'out of line' with that for doctors as a whole i.e. 13 per cent aged 60 and above (see

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10 The 29 were made up as follows: Birmingham -9 (out of 18), Nottinghamshire -9 (10), Staffordshire - 3 (4), Leicestershire - 3 (4), Sheffield - 1 (3), Derbyshire - 2 (2), Worcester -1 (1), Coventry -1(1). This response rate was considered to be very good in all areas except Birmingham, which had the highest concentration of single-handed women GPs.

11 My least successful attempts were mainly amongst the Birmingham GPs, where only half participated.

Table 3.2). However, the sample is too small to break down for separate analysis of age/ethnicity. Beyond this it is not possible to speculate, because there is no previous research to refer to. Hopefully, this research may serve as a 'marker' for subsequent studies.

The list of themes and issues to be covered was based on several sources. The 'women lawyers' project interview schedule was particularly important in forming the perceptions I had of the shape my interviews would take. It was from the interview schedule and my wider reading that I formed the basis of my ideas on gender and professional women, which were developed into key words/issues. Issues pertaining to medicine and general practice came from my own experience and knowledge and from the relevant literature that I had covered so far. In addition, discussions with a number of other people helped me form the basis for my interviews which were modified after the six 'pilot' interviews had been conducted. The outline structure upon which the 29 interviews were based is included as Appendix B. As indicated above, this was only an outline, a list of key words, themes and issues, and I certainly did not envisage any two interviews being alike. The outline was to be no more than a guide; in fact this is how it worked. It was also intended to give me credibility as an interviewer vis a vis the respondent in seeming to carry some preparatory notes and structure with me.[12] I did not alter any aspects of the actual guidelines I carried with me to each interview, but the schedule was sufficiently flexible that I was able

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12 See below where professionalism and status are discussed.

to respond freely to the GPs on the basis of what they said. The guide was not always wholly appropriate in every interview and to a great extent I relied on my memory and reactions to issues, perceptions and experiences which the doctors raised. At times I was able to feed back to them, particularly with the later interviews, ideas which had been raised in earlier interviews by other GPs for their comment and opinion, or for comparison with their own experiences. This was 'grounded theory' in action. Interviewing was a living and dynamic process.

The process and dynamics of interviewing is complex and a number of factors need to be considered to understand how the process worked since it is fundamental to the outcome of the project as whole. I shall, therefore, consider the following interconnected features in the interviewing process: gender, age and knowledge, and then I shall also look at ethnicity as a factor in the interviewing process.

4.2 Gender, age and knowledge

Understanding the influence of gender as a dynamic in the interviewing process is particularly important in a study such as this one which takes gender as its central focus. A woman (myself) interviewing women (the GPs) could be viewed as unproblematic, but as others (e.g. Scott, 1984; Finch, 1984) have shown, this is far from the case. Interviewing men for the 'women lawyers' project had a strong influence on the form I thought the women doctors interviews would take. McKee and O'Brien (1983) have shown how the female interviewer may be at some risk in the interview situation with men. While there were no instances when I felt at risk during the interviewing of the men lawyers, there was obvious and

demonstrable interviewer effect in terms of gender. On one occasion, for example, a male lawyer asked me out after the completion of the interview.[13] Such experiences had some effect on my style of interviewing. With the remainder of the men lawyers I smiled less and remained more remote, distant and outwardly objective so as not to appear too encouraging in my manner. And it was my experience with the men lawyers which crucially affected my interviewing style with the women GPs. By the time I commenced the interviewing of the women GPs I had perfected a distant manner which it took some time for me to break down. It soon became apparent to me too that the non-interventionist interviewing of the 'women lawyers' project was less suited to that of my own project.

The issue of women interviewing women has been discussed by, for example, Finch (1984) where she compares her part in interviews with two different groups of women. The first, wives of the clergy, were more comparable to the women GPs than her second group of playgroup mothers. However, location of interview was not comparable, since she interviewed all the women in their homes (the private sphere), while I interviewed all but three of the women GPs in their surgeries (the public sphere). Like Finch I found I was surprised by the readiness with which **some** of the women talked with me, but the rapport which she found to be instantly established was not the case in all my interviews and had to be gradually set up. I think this had more to do with external factors than a

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13 There were occasions where I most definitely did feel at risk from male respondents on interviews on later research studies in which I was involved.

lack of the "personal qualities" which Finch discusses. By external factors I mean that the interviewing of women in their surgeries puts the whole interview on a different footing from interviewing them in their homes. The single-handed women GPs were in their professional environment, in a situation where others usually 'exposed' themselves to them, rather than the other way round. In their surgeries too, many of them were constantly having to change from their role of interviewee back to professional - answering the telephone and speaking to patients or interacting with the receptionist or secretary on a 'professional' basis. In addition, there were some GPs who did not devote their whole undivided attention to the interview - they wrote up notes, signed prescriptions, wrote letters and so on, at the same time as talking to me. For the most part, they gradually did give more of themselves to the interview as it progressed, but the possibility of interruptions calling them back to their 'professional' role (particularly from the telephone) still occurred.

Another consideration in interviewing in the doctor's work environment was her professional status. As doctors inculcated into the male professional ethos, self exposure was something they were wary of. In order to 'survive' in the male-dominated professional world they had protected themselves by becoming 'professional' in the male sense of the word. This made it vital for me to build up some sort of trust with them before they would drop the professional barriers. While the men lawyers had been surprised at being asked questions about the division of labour in the home - responses had been less spontaneous than those of the women lawyers - some of the women GPs were also not very responsive about the domestic aspect of their lives, talking as they were in the professional environment of their surgeries. On the whole, the younger GPs were more giving, more

responsive to me than the older ones, who were perhaps more steeped in the male image of the professional. However, my own part in this discussion is crucial, because when talking of professional/status/age aspects of the interviewing process, these all interacted with my gender.

While at present in my mid-thirties (early thirties at the time of interviewing) I have always been taken to be several years younger than I actually am. This, in the interviewing situation, has affected perceptions of me in terms of my status and as a 'professional' researcher. I was frequently asked by the women GPs (and indeed in other interviewing situations too) whether I was conducting a student project. My response to such questions was varied. It was apparent, when asking me about a **student** project, that 'student' was viewed as an undergraduate student. If I explained I was a postgraduate student, this did not necessarily raise the status of my project in their eyes. If I said that I was not a student my status was still under suspicion. In any case, I came from the Department of Sociology and Social History (as it was then) and what sort of profession was sociologist in any case? I had not come along with any 'scientifically' constructed questionnaire on which to base my interview, so I appeared ill-prepared in 'scientific research' terms. As doctors, steeped in a scientific background, they naturally suspected a research approach which did not seem to incorporate any of the accepted or known methods of collecting data. Scott (1984) has discussed this aspect of interviewing from her own research on sociologists. She saw her status as changing with different

status sociologists,[14] but equally her research methods were frequently challenged by respondents. Woodward and Chisholm (1981), too, discussed the issues of the supposed legitimacy of research techniques and marginal status for themselves as young, female, junior, feminist researchers.

These questions of professional/status/age aspects of interviewing are important ones in understanding the process of reseach. However, intrinsic to all those aspects is the influence of gender. Having achieved in a male-dominated profession (given all the gender-related factors in their careers and lives) the women GPs perceived 'the professional' in the traditional manner as male and of status - in an image which I was unable to fulfil. In effect, my deviant age/status meant that I had to work harder to 'pull off' the interviews successfully. However, although these were factors in consideration of the dynamics of the interviewing process, they do not undermine the value of the data collected, only add a dimension to understanding them.

4.3 Ethnicity

The issue of ethnicity was something I had not considered in any depth before the commencement of interviewing. At the time I still did not know what proportion of my respondents would be Asian, although I was aware

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14 As Scott comments:

> Some academics treated me as a peer, some were extremely high-handed; some postgraduates treated me as a peer, others saw me as more knowledgeable and powerful than themselves, and others, notably male part-timers in senior posts, saw me as less powerful (1984: 171)

that they did constitute a proportion of the 43 names which I had. It transpired that 11 of the 29 doctors were of Asian origin and they raise further issues in the dynamics of interviewing, which I was not wholly prepared for. However, it was evident from early on in the interviewing that of the GPs who were less responsive to me, most were from amongst those of Asian origin. It is, though, by looking at the interview process with the Asian GPs that the gender dimensions in interviewing are clarified. There are clear parallels to be drawn between them. The fact that the less responsive GPs were the Asian ones seems to demonstrate a number of factors. First, the effect of having a white interviewer was important, and could suggest that this was as strong an influence as that of gender. Not only were the Asian women GPs less open and forthcoming in treating the whole process as a question and answer session, but they also were much less open in the sorts of responses they gave, most particularly in describing their domestic situations. There seemed much less willingness to be critical of others both in their public and private spheres. There was little of the instant rapport which Oakley (1981) and Finch (1984) have described as occurring between women which was much more apparent with the white doctors. In addition, I felt much more apologetic at asking the Asian women to describe aspects of their lives which I, as a white person, could be viewed as contributing to in terms of their oppression. In effect, I was the 'powerful' interviewing the 'powerless' (Pettigrew, 1981). I was definitely less effective in encouraging them to tell me about the effects of racism and the influence of their ethnicity in a white society, as can be seen in chapter 12 where ethnicity is considered. There were, in fact, times that I felt I was being rejected as the Asian doctors glossed over

situations and experiences. It was thus much more difficult to get 'inside' the lives of the Asian doctors than was the case with the white doctors.[15]

The effect of a white interviewer is, therefore, central to the sort of information I was able to get from the Asian doctors, but the whole idea of the 'interview' is problematic too. The problem of 'the interview' in feminist terms will be discussed below, but for the present discussion it was evident that the Asian doctors treated the whole process much more like an interview than did the other respondents. By this I mean that they often gave one word or one sentence 'answers' to my 'questions' and where they had more to say on a specific area they would stop at the end of it and wait for another 'question'. In effect, the interviews were mostly much less conversational and reciprocal, rapport seemed much more difficult to attain and consequently the Asian women GPs became more 'objectified' in the interviewing process.[16]

Nevertheless, the 'interviews' with the Asian women GPs were valuable and successfully contributed an understanding of their perceptions and experiences as single-handed general practitioners and of other aspects of their lives. For the most part the analysis does not draw out the Asians, because for the majority of the analysis the sample is taken as a whole. This obviously begs some questions, but the Asian women doctors are considered separately in chapter 12 which shows how such perceptions alter their overall experience of practising as women doctors in the UK.

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15 This comment begs the question as to how successful I was at getting 'inside' the situation with any of the GPs. The word 'inside' of course is used in relative terms.

16 See Oakley's (1981) comments below on the part played by the interviewer in objectifying the respondent.

4.4 Case studies and contextual outlines

Having completed the 29 interviews, my next step was to study some of the women in greater depth by watching them at work, spending time in their surgeries, observing consultations and accompanying them on home visits. I decided for logistic reasons that it would be easiest if I could get the cooperation of local GPs since this would not necessitate staying away overnight in order to be at the surgery in time for morning surgery at 8 or 8.30 a.m. I approached five of the GPs at the end of the interview and all agreed to allow me to spend a day with each of them, provided I obtained written permission to do so from the Family Practitioner Committee. This I was able to do surprisingly easily. I had imagined that all sorts of problems of breach of confidentiality in sitting in on patient consultations would be raised, but they were not.

Two of the five GPs who had agreed to participate in this next stage of the research dropped out when I telephoned to arrange a date,[17] but I was able to observe three (doctors 18, 22 and 20)[18] for one day each. All three doctors introduced me to each patient when they came into the surgery, advising them that I was there to observe the doctor not the patient. One doctor (no 20) put a sign in the waiting room advising them of my presence. No patients asked me to leave the surgery for their consultation,

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17 One dropped out because she said she felt self conscious in being observed, while the other said through her receptionist that "we've asked patients and they won't agree to it". I suspected that this was an excuse rather than the truth but had to accept this explanation.

18 This was the order in which the three GPs were observed in their practices.

but it is not possible to know what effect my presence may have had on the doctor-patient relationship. I do not know whether patients withheld information from the doctor, or whether they were more open because of my presence. Equally, I do not know whether the doctors listened more, or were more thorough than usual because of my presence. In any case, this was not really the focus of my research. Rather, I was intent on getting a feeling for their practices and what it is like to practise single-handed. In retrospect, I would say that I was not able to get a very profound understanding of this in so short a time, but I suspect that asking to spend much more time with the GPs would have been counterproductive since I doubt whether they would have been willing to tolerate more than a day of this sort of observation. I may have been wrong about this, but I did not risk putting it to the test. This also affected any ideas I had on collecting data from other sources. I felt that I had stretched cooperation from many of these GPs to the limit and it would possibly stretch their tolerance beyond the limit to attempt any other supplementary means of collecting data, for example by asking to consult practice records and documents, or seeking to interview patients. In any case, I felt that I had managed to collect very rich data from the methods I had used (the interviews and case studies).

In the event, the three days spent with doctors 18, 22 and 20 were certainly valuable in enhancing my understanding of some of the difficulties and attractions of single-handed practice. The case studies are presented in full in chapter 5.

In addition, I felt that, while the value of the case studies was that they put three of the women GPs into some sort of context and gave a 'flavour' of

their practices, as well as providing a contextual background for the other 26, a brief summary of each would also be of benefit. It would allow the reader ready referral at any stage to see how particular themes fitted into the whole. This seemed particularly important in respect of the Asian GPs, since it allowed a clearer understanding of how these affected the whole analysis. It also enabled issues such as age comparisons to be fitted against experience. In addition, the individual characteristics of each woman GP and her experiences could be more clearly understood. These 'contextual outlines' are included as Appendix C.

4.5 Analysis and feminism

At this point I needed to reconsider the question of my research design. As I progressed with interviewing the 29 women GPs I was becoming more and more convinced of the value of the information and data which I was collecting in its own right. However, the issue of developing the research into a comparative study was still a live one. The possible comparisons were between these single-handed women GPs and women GPs practising in groups, or with single-handed men GPs. I rejected the idea of a comparison with women GPs in groups because I felt that I had a rich data source - many of the single-handed women GPs had practised in groups and partnerships in the past. Consequently there was plenty of material on group practice available within the existing data source which could be drawn out; chapter 7 covers this aspect of the analysis. However, there was no such 'built in' comparison in respect of the second possible element - single-handed men GPs. I decided not to interview a group of single-handed men practitioners for several reasons. First this would have lengthened the project even more. Second, I was not collecting much quantitative data

(which would have been particularly susceptible to systematic comparisons) for reasons which have been made clear. Third, and important, I felt strongly that a comparison with men would tend to legitimise men as the norm and make the women GPs appear as deviant (on the temptation to do this, even by the feminist writer, see Legge (1987:56)). This particular group of single-handed practitioners may be deviant in respect of other women GPs but women GPs as a whole should not be viewed as such. Nor did I feel that the women should be viewed as adjuncts to men. This is a factor which has been identified by Bernard:

> The topics that have preoccupied sociologists have been the topics that preoccupy men, power, work, climbing the occupational ladder, conflict, and sex - but not women - or women only as adjuncts to men. .....Very little sociology deals with the nature, structure, and functioning of a female status world... (1973:783).
>
> ....a disproportionately large amount of research has been invested in the sociology of sex as a variable and a correspondingly smaller amount in the sociology of women as a collectivity, or as simply people. A great deal of research focuses on men with no reference at all to women; but when research is focused on women, it is almost always with reference to men. If comparisons are not made with men, the research is viewed as incomplete. (1973:787).

I therefore decided to let the women speak for themselves with reference to no one else. In retrospect I feel that a comparison with other women GPs who have used other strategies than practising alone to counter the problems they face in everyday practice (i.e. women in group practice) would add another valuable dimension to an understanding of women GPs. (This would, of course, have meant a much more lengthy research project.) However, I stand by my decision not to interview single-handed men GPs and would add that this was also in a sense a 'political' decision as a feminist - this point will be considered below.

I started transcribing the tapes from my interviews during the four months that the 29 interviews took to complete, but it was evident that the pace of my interviewing meant that I was unable to keep up with the laborious task of transcription and the process continued for several months after the completion of the interviewing. I would suggest, therefore, that the 'grounded theory' approach was not working to its full potential since I certainly missed or forgot to include areas of discussion which had occurred in the previous interviews which I had not yet transcribed. For the 'grounded theory' approach to work to its full potential, I would suggest, it is necessary for the researcher to become fully familiar with the whole interview content by reading and re-reading the transcripts, which was something I was not able to do. In retrospect, it would have been better to have spaced the interviews over a longer time scale so that each interview could be transcribed before proceeding with the next. I suspect there may have been emerging issues which I would have pursued more rigorously than I did had I adopted this approach.

Once the transcription and the case studies had been completed, as well as the observational notes I had made about each doctor after leaving her, I moved on to the analysis proper. In accordance with the 'grounded theory' approach, analysis had, of course, started to occur from the very beginning of the project. By the end of the 'field work' the analysis was well progressed. However, I did not until a much later stage begin to consider the influence of my feminism on the study.

Before considering the impact of feminism itself on the research process, analysis and writing up of the study, it is necessary to look more closely at

the way in which the analysis evolved over time and out of itself. I have already noted how the 'grounded theory' approach was not totally successful but that, despite this recognition, the final themes of the data became clearer as they gradually presented themselves. I started the analysis from the premise of the 'women lawyers' project (and countless others) by viewing the whole 'story' in a chronological order, so that I divided the data up into different stages in the doctors' life cycles. But the dividing up of the data was more complex than that because it was evident that particular themes presented themselves not just at different stages of the life cycle, but also subsumed the life cycle. Therefore, themes evolved sequentially out of the chronological progression of the interviews, but also distinct aspects of the respondents' lives presented themselves as themes which cut across the strict chronology of the life cycle approach. Some themes were familiar ones, for example the domestic sphere, and came out of both the 'women lawyers' project (where this had been a major thread of the study) and the vast body of literature which examines this aspect of women's lives. Other themes emerged, however, directly from the data produced from the interviews with the women GPs. One particularly important theme was that of out-of-hours cover; in discussing this I was able to examine the important interface between the professional (public) and domestic (private) spheres of single-handed women GPs' lives. Long before the time that the final interview had been completed, it was evident which were to be the important themes in the study.

It was necessary to support the evolution of these themes with a rigorous and systematic ordering of the data. Since I had been encouraging my respondents to explain and describe experiences and perceptions of their lives, it was important that I used what they had actually said in

categorising their comments, rather than implanting my own interpretation of those comments at too early a stage in the analysis. My ambition from the start had been to let these women 'speak for themselves'. Therefore, I decided not to impose on the transcripts a scheme for categorising responses, such as the method of picking key words and searching the transcripts for these. Rather, I picked out the major themes which had clearly evolved by the end of the interviewing and reading and rereading of the transcripts; then I systematically went through each interview cutting out those comments made by each doctor on a particular theme and sticking them onto cards. I thus compiled a set of cards for each theme with the comments of every doctor on every particular theme. This meant that there where certain comments straddled more than one theme they appeared on the cards for each theme to which they applied. By this method I was able to see almost at a glance what had been said by which doctor on a particular theme. Each comment was indexed by the interview number and transcript page, facilitating easy referral back to the original transcripts. Although this proved to be a long and time consuming exercise (even for only 29 interviews the total number of pages of transcript was 367) it not only simplified and clarified the final process of analysis and writing, but also allowed themes to emerge which had not been seen as important early in the research. To reiterate the theme of 'out-of-hours' cover, this was the one which it became evident would not fit neatly into the 'professional sphere' theme nor the 'domestic sphere' theme and was also one which came to give shape to the overall gender emphasis of the thesis.

The detailed rearrangement of the data onto cards enabled me to become very familiar with the content of the interviews. By the time of the final

analysis and writing up stages I knew intimately what doctor 14 or doctor 6 for example, had said at any given time about any given topic and how these fitted into the various themes which had emerged. It was this familiarity with the content of the interviews which allowed me to move to another important stage of the analysis, and to then lay my own interpretation over the emerging data. This interpretation was informed by a political 'feminist' perspective.

Several researchers in Roberts' (1981 c) volume on feminist research have shown how their feminism affected the whole research process and analysis and this is no less true of my own research. And I would suggest that my development as both a researcher and a feminist were strategic to the way the analysis has been written up. By this I mean that my understanding of feminism has developed in leaps and bounds over the time I have been conducting the research itself and writing it up. In addition, my experience as a researcher in that time has also changed in the way I have interpreted the information I collected. The development of this PhD thesis through all its stages has gone hand-in-hand with my own development as a researcher,[19] a feminist and a person. I would now say that, like Stanley and Wise (1983), I try to "do" feminism in my everyday life, rather than reserving it for specialist activities. This has been a feature of my personal development, but I have not been wholly successful. A case in point is shown by looking at my terminology. The concept of the 'interview' has been used throughout. Oakley (1981) has defined the interview as a one-way process which 'objectifies' women and, in a sense, this was how I viewed my 'interviews' when I conducted them. As Oakley comments:

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19 I have been involved as a research worker in several other projects during the whole period of completing this thesis.

> ... when a feminist interviews women: (1) use of prescribed interviewing practice is morally indefensible; (2) general and irreconcilable contradictions at the heart of the textbook paradigm are exposed; and (3) it becomes clear that, in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship. (1981: 41)

I would say now, though, that in most cases I put myself into the situation in such a way as not to objectify them. My understanding of this, therefore, has developed along with my feminism. My purpose at the later stage of writing has been to bring out the 'subjective' elements of the 'interview' interaction, rather than the 'objective' view of the doctors as distant and not alive. I would suggest that this understanding says something about all research. PhD research is often viewed as different from any other research because it is acknowledged as a learning process of "how to do" research, while the researcher is supposed to come to any other research project as an 'expert' at research who will give 'expert' answers at the end of it. However, there is no difference in fact - research is always a learning process and evolutionary. My feminism and my own development has continually evolved over the time of conducting this study, and throughout the analysis and writing up of the thesis. I would expect this to occur in future occasions where I do research. This means that interpretation of the same information or 'data' can change with the researcher's own development. I think this is an important consideration in understanding this piece of research in my becoming **more** feminist, **more** experienced or whatever as the research has progressed. Cicourel raised the issue of the part played by the researcher:

> Researchers in the Social Sciences are faced with a unique methodological problem; the very conditions of their research constitute an important complex variable for what passes as the findings of their investigations. Field research ... is a method in which the activities of the investigator play a crucial role in the data obtained. (1964:39)

And many researchers have carried this argument further in incorporating the part of the feminist in this process. However, I am suggesting, as other feminists have done, that the 'dynamics' of the research process continue into the analysis and writing up of research and beyond. In this way the experience of research continues to develop.

These factors should be considered in understanding this thesis. I continually question my success in presenting the women GPs for scrutiny. I would suggest that this is less due to my own lack of confidence than to my changing understanding and the development of others in the process of research and feminist understanding. The single-handed women GPs, as far as I have allowed them, speak for themselves in what follows.

CHAPTER FIVE

THREE CASE STUDIES

This chapter begins the examination of the data collected in this study of the single-handed women GPs. While chapters 6 to 12 analyse the data by topics or issues and draw on all the interviews in the process, a different approach is employed here. By examining in detail three of the single-handed women GPs as separate cases in terms of the issues covered in the ensuing chapters, the different topics covered are given a continuity. Whilst such continuity is produced, the three separate cases are different enough to demonstrate the diversity of issues examined in the whole study. They are good examples from which to begin the analysis of single-handed general practice and, hopefully, give a 'feel' for what it is like for women GPs to practise on their own. However, there are some aspects of the women's experiences which make them valuable in demonstrating trends which seem to be peculiar to single-handed women GPs, which are examined in later chapters. The three GPs are different in terms of age (29, 46 and 52); ethnicity (British - white, British - Chinese, and South Asian - Indian); practice premises (health authority clinic, surgery attached to home and poor inner-city run-down building). But there are certain similarities in terms of the arrangements made for out-of-hours cover and use of deputising services, as well as in other respects.

As indicated in chapter 4, the three women GPs who were studied in greater depth were picked strategically after the completion of the initial interviews in order to be able to demonstrate differences and similarities in

single-handed practice in the way described above. Inevitably, other cases could have been pursued to illustrate other issues important to the research, but with the issue of gender crucially central to the study, cases which brought out the gender issues most clearly were a priority in the choice.

In addition to the data collected at interview, a considerable amount of time was spent with these women in their surgeries, in consultation with patients, interacting with other practice staff, on home visits and in further general conversation. This gave both a broader and deeper view of many of the issues raised in the original interviews, and a vivid picture of the working of a single-handed practice and GP. It proved valuable in adding substance to the interviews and placing them in context for particular study.

The use of these three cases, however, does not preclude their inclusion as sources of data and illustration in later chapters. In fact, as is often the case with interviews (as discussed in chapter 4 above), some respondents voiced their opinions with particular clarity, while others only implied their views. It is the former, of course, who provide the best material for illustrating the analyses and who consequently tend to appear regularly throughout this study; but the latter are also used where appropriate. The three GPs who form the case studies were particularly articulate and, of course, the researcher spent much longer in their company than with the other 26 GPs. This is a further reason why these individuals make good material for use as case studies. The case studies are mainly descriptive and the analysis is carried out in later chapters. All 29 GPs are described in contextual tables in Appendix D, while equivalent tables are also included in this chapter for the three GPs described below.

5.1 Doctor 18[1]

She was a 46 year old woman of Chinese origin who was educated in Britain from the age of 16 onwards.

The path to general practice

She had wanted to go into medicine from the age of 10 and had always had the idea in her mind of becoming a general practitioner. As she explained it:

> I suppose it's a feeling of wanting an association with community, or being part of a community, or contributing something to a community.

No other members of her family were doctors. She had no difficulties to relate about entry to medical school or her time there. In fact, having married before going to medical school meant that she had the support of training together with her husband. She had three children while still a medical student and this had inevitably been disruptive but nevertheless she had not lost any time or failed any examinations. She said of this period of her life:

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1 The case studies are presented in order of study i.e. doctor 18 was the first of the doctors to be revisited after initial interview, followed by doctor 22 and then doctor 20.

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
46	British (Chinese)	Separated	Doctor - psychiatrist	4 (2 adult and 21, 19)	"I had the idea that ... wives are somewhat subservient to husbands and ... were responsible for the running of the house ... husbands weren't expected to take part in any of this ... but this isn't essentially myself, so I always had this conflict about having my own ideas ... to try and match that up with my ideas about being a wife ... I could never really resolve that conflict ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"My mother and I decided when I was about 10 or 11 ... I suppose its a sort of feeling of ... contributing something to a community ... and that's why I chose general practice"	Not given	"... I happened to conceive three times, but that wasn't really a problem for me because I happened to have them in the holidays..!"	(1) ? house jobs (2) SHO psychiatry (3) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None - except locum	Attached to home	Good	One receptionist. Use of Health Visitor, Midwife.	1532	"Deputising service? Whenever I'm out which is probably one evening a week ... and (if) it's late at night and I'm afraid to go out alone"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... at one time I thought of doing surgery ... and I decided against it because ... it would mean giving up everything in one's life because surgery's such a competitive field"	"I think the intake should be ... two thirds men, one third women ... I think that ... would be fair enough"	"I suppose really the satisfactions are ... sitting in here, somebody comes in with a problem, and you understand the problem, or you make the diagnosis ... and you know the treatment ... that's very satisfying"	"I've got what I want from the point of view of the practice I started myself, and I organise and run the way that I like"

> (it) wasn't really a problem because I happened to have them in the holidays so I didn't miss any lectures or exams because of them.

After her registration house jobs she worked for 18 months as a Senior House Officer in psychiatry with the idea that this would provide a good background for general practice, but she had no plans to go on and specialise further.

The experience of general practice

Doctor 18 had not only known from a young age that she wanted to be a doctor and a GP, but she had also always wanted to practise single-handed. Her early experiences in medicine, therefore, were in effect geared around the idea of its suitability to a future in general practice. Following her post in psychiatry she did not go immediately into a single-handed practice. This was primarily for logistic reasons - she did not want to be dependent on a partner, or be involved in any rota system to cover out-of-hours calls and so decided to wait for the imminent start of the deputising service. She took a locum appointment in general practice for three months and then had the option of working for the deputising service when it started, but decided that the commitment of four children[2] meant that she was not free enough to do so. She started her own practice a few months after the deputising service began, because in that way:

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2 Her fourth child had been born after she qualified as a doctor.

> I was able to be single-handed and have help when I needed it .... we bought a house .... and as we were moving in somebody came and asked .... well the patients in that area knew I was coming because that's where I'd done the locum, and I said that I'd be coming shortly, because that doctor had already left the area .... and his practice was in fact disbanded, so as we were moving into the house, people started inquiring when I would be ready to start .... and it didn't take long to build up a reasonable number.

The practice was a reasonably small one with about 1500 patients, but she found this a good level for her, because of her other commitments. She worked as a hospital practitioner in psychiatry which involved two sessions a week. She used the deputising service only a small amount:

> whenever I'm out, which is probably one evening a week.

She also covered most night calls herself, except if it was a patient she did not know, when she used the deputising service.

Rather than using the deputising service when she and/or her receptionist (who did morning and evening surgeries) were out during the day, she had an answerphone giving details of the appropriate time to ring again, or the telephone number of the deputising service for emergencies. She used an appointment system which meant patients rarely had to wait more than a few minutes, except for those who "arrive half an hour before their appointment!"

She saw herself remaining in the same practice and working single-handed for the foreseeable future. Although she had once considered taking a partner this had not worked out. Her attitude to the idea of a partner was that:

> (it's) very much like having a husband or wife, you know, it's a lot of hassle, and .... you spend a lot of energy sort of coping with a partner, whereas you could be using that energy somewhere else.

The domestic sphere

Having four children, three while still a medical student, placed this GP in a particularly difficult position where reconciling professional and domestic lives was concerned. She had her first child in her second year of study, but said of having three children during that hectic period of her life that it had not been a problem, except that:

> Looking back on it my only regret about having had them at that time was the fact that I couldn't look after them myself.

This statement epitomises the sorts of doubts (and decisions) which have to be made by many professional women in the same situation.

The compromise she had to make for having children at that time was to have her mother-in-law living with herself and her husband. And while that relieved the practical problem it brought its own difficulties:

> My mother-in-law came to stay with us, and that wasn't a terribly good idea as far as the marriage was concerned, because having one s mother-in-law .... we didn't get on that well, and then I think there's a lack of privacy, when you have somebody else living with you, and especially a young married couple, you know, before you've had time to sort out your differences, I mean you can't even have a decent row, if there's somebody else in your house. .... I think the only regrets I have are those.

It may be that her children suffered. She had her fourth child after she had finished her hospital house jobs and she said:

> I think the children would have been better off had the fourth been the first .... and I think I would have coped better or been able to offer them more ....

Another aspect she had to reconcile was in the actual running of the home and the responsibility that this involved. In a very telling phrase about this aspect of her life, when talking about fitting in study for examinations, she said:

> You know having my husband, he was a great help, sort of while I got the supper he would stand there and tell me things.

This implies that housework, cooking and so on were her responsibility, and this was confirmed later in the interview. It is useful to quote in full her perception of her role in marriage:

> I suppose I was at a slight disadvantage in my marriage because .... I know this doesn't only apply to Chinese, and not all Chinese are brought up in this way, but somehow I had the idea that wives are somewhat subservient to husbands and the wives were responsible for the running of the house and so on, and if they decided to work, well they could work .... provided they could run the house and all this sort of thing smoothly, and the husbands weren't expected to take part in any of this .... and the husband was the boss and the wife had to do, you know, as she was told and this sort of thing, but I sort of grew up with this sort of idea in mind, but this isn't .... essentially myself, so I always had this conflict about having my own ideas and sort of by nature being a fairly independent minded sort of person .... who likes to have ideas, make decisions and carry them out, and this was really a great problem, to try and match that up with my ideas about being a wife, and I could never really resolve that conflict ....

Her husband's response was that of someone with a similar upbringing, so that:

> (while) I insisted that I did all the housework, I just took on the responsibility for running the house .... and he sort of fell in with that, (because he'd been) brought up with a similar idea that the husband doesn't do any housework, wash the dishes or that kind of thing ....

Because such an attitude is almost irreconcilable with a wife having a full time professional life, the unresolved conflict she talked about led to resentment at her husband's acceptance of the situation and his lack of support on the domestic side. She said that she felt "stuck" because she was living up to her conditioning:

> .... but somehow it seemed a bit unfair .... and I suppose for that reason .... I decided that marriage isn't for me anyway, and I would never marry again because I just couldn't cope with this conflict of being a wife as I see it

In many ways it was easier after separating from her husband. They separated very soon after she started up her practice. Since the surgery was in the house where she was living, the children could be in bed while she was running a surgery and she could pop in and out between patients if necessary. The biggest problem with the children was when she was called out at night, and very often she had to take them with her in the car while they were too young to be left alone.

She said that she never thought of reconciling professional and domestic lives as any great problem, since "you just do it". However, she admitted later in the interview:

> .... sometimes it was difficult, you know, you found yourself with having to do about three things at a time, and you'd think oh god .... how am I going to manage, or you'd get into a terrible state .... thinking well .... I've sort of two days work to do today, and you get slightly panicky, because you think well, will I be able to cope, but you know, somehow you do it, and then it gives you a bit more confidence for the future, so I don't regret having had .... hard times .... at certain stages of my life ....

For her, a greater problem after separating from her husband was the financial worry:

> I remember I used to do all the washing, the sheets, the towels, the blankets, the whole lot by hand, to save 2/6 at the launderette.

Although she underplayed the difficulties which she had faced, this GP is a very good example of the problem of reconciling the domestic situation with a full professional life. It raises a number of questions which will be considered in detail in chapters 9 and 10.

Attitudes and Aspirations

Doctor 18 talked at some length about what she felt were the advantages and disadvantages for women in medicine. She never felt that she had been discriminated against as a woman. In terms of a career she felt that in some senses there had been disadvantages in having to bring up children as well, but she explained:

> I just accept the fact that women are responsible .... for the house and for the upbringing of children, so that you have to set your sights slightly lower if you want to fit this in.

So she did not question the position which many women find themselves in but, rather, saw the situation as an advantage for women. It is worth looking further at this comment since it expresses a different opinion to that of any other woman GP in the study. In effect it turns around the traditional arguments about women's "double burden". She said of women:

> They have a choice, I mean a woman can say right, I'm going to pursue my career, and pursue it in the same way that a man's able to.

She had at one time thought of doing surgery but had decided against it because:

> .... it would mean giving up everything in one's life because surgery's such a competitive field, it is even for men. I mean they have to be .... sort of single-minded about it, and I realised that I would have to be terribly single minded and sort of give up everything else in my life .... Well I wasn't prepared to do that, so I decided .... that isn't for me .... and so you have to decide well, how much you are prepared to give up and so on and decide well what do you want out of life, and fit in as best you can. So that if you decide right, you want .... a family .... well you have to give a certain amount to that, so that obviously you can't pursue your career in the same way as a .... man would be able to do. You can't aim to be a professor or you know something terribly academic or something terribly demanding.

The important point here is that she did not see this limitation to her career prospects as burdensome, or representing a sacrifice or a waste of talent. As she said:

> It's up to the individual to decide what they want out of life really .... because you're a woman and because you might want a family .... this is (not) necessarily a disadvantage to you. To my own way of thinking it's an advantage because you know

> women have such .... a choice .... we have a much bigger scope in what we can do with our lives than men do, I mean men's lives are fairly narrow when you think about it.

She suggested that men find their identity in their career, and put most of their energy there, "so I think women have a better time". In fact, she did not see any particular advantages in medicine for women, because she felt that "medicine is one of those careers where it (being a woman) doesn't matter terribly."

Doctor 18 saw a clear advantage for the patients in having a woman doctor.

> .... in the sense that a lot of women feel that lady doctors are somewhat more sympathetic to their needs because being women they feel that they can understand them better and .... appreciate what they're going through .... But one doesn't have to be a woman to understand this and there are a lot of .... men doctors who probably understand women better than women doctors understand women, so that I think it's a bit difficult to generalise ....

She thought that the fact that she saw more women in her surgeries was because:

> I think generally speaking there's a high percentage of consultations sought by women

rather than that women patients **preferred** a woman doctor.

She found general practice very satisfying and one of the main satisfactions of it was:

> .... somebody comes in with a problem, and you understand the problem, or you make the diagnosis and .... you know the treatment. I mean there are very few pleasures as great as that....

This doctor had very definite views on the so-called 'wastage' of training women doctors who do not then practise:

> I wouldn't really call it a waste in the sense that .... you have to ask, you know, what's the meaning of life .... what's the purpose of life ....? So that at the time these women decided to go into medicine, I mean that's what they wanted to do with their time, and because they stop and have children .... it doesn't mean that it's entirely wasted, I mean a lot of what they've learnt and so on would be used in different ways.

She did, however, think that fewer women should be admitted to medical school than men, because:

> .... the chances of a woman dropping out are so much greater than a man dropping out or not practising.

She felt this would be fair because you then:

> get the ones who are more highly motivated, more bright or whatever .... it might be unfair but life is unfair ....

In effect, this GP seemed to be advocating the status quo as far as women and medicine were concerned.

A day in the life ....

A day was spent with Doctor 18 in her surgery - a day which she later summed up as "fairly typical", giving a good idea of how her practice ran. The practice was in a suburb of a big city. The doctor had bought two neighbouring semi-detached houses and connected them inside, with the waiting room and reception area in the front room of one house, which led into the surgery which was the front room of the next door house. The remainder of the two houses was used as living accommodation for the doctor and the two children still living with her. The surgery and waiting-room were light, well- carpeted, decorated and furnished. The waiting room had a reception area, magazines for patients to read while waiting and a few toys for children. The surgery, although small, consisted of desk, an examination couch behind a curtain in one corner, a trolley with instruments, steriliser, cupboards, filing cabinets and wash-hand basin.

Surgery commenced at 8.30a.m. Patients came on an appointments system. After the first patient had left a representative from a drug company spent 10 minutes in the surgery, which was followed by a gap until patients started coming again. There were another nine patients before surgery ended at 9.45a.m. All patients came with a physical complaint or to renew prescriptions except for one who came to sort out invalidity benefit problems. At the end of surgery the doctor then spent a short time signing letters and repeat prescriptions. Then approximately one hour was taken over a coffee break - but, she pointed out, this time was usually also used for letter and report writing and so on, or for home visits. There were in fact no home visits needed that day. The doctor then went off to run two psychiatric clinics at a local hospital, which she did twice a week.

These finished at 3.30p.m. and she had until 5p.m. free when evening surgery commenced. This lasted until 6.30p.m. but was very slow - only five patients attended and there were long gaps between each one. After 6.30p.m. she usually did any more home visits which were necessary, but there were none that day. Before she left she switched calls through to the deputising service until the following morning. The general feeling was of a warm, unrushed and homely atmosphere.

5.2 Doctor 22

Doctor 22 was a 52 year old Indian-born woman and this second case study presents a different picture to the first in many ways.

The path to general practice

Coming from a family of doctors, she had wanted to do medicine from the very early age of four. She did her medical training in India, which went very smoothly. She then worked in paediatrics in government hospitals for three years before coming to Britain, being married to a British-trained, Indian-born architect who had gone back to India for a year "to look for a wife". When she came to Britain Doctor 22 spent the next nine years in psychiatry, finishing with a non-consultant hospital post in psychiatry around the time of the birth of her third child. She also had to do six months as a house officer in obstetrics and gynaecology in order to get full registration, since much of her Indian experience was not acknowledged. Her last hospital post was as a casualty officer before going into general practice, although she continued doing psychiatric sessions for several years. After nine years she decided to leave full-time hospital medicine (for general practice) because of ill health.

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
52	Asian (India)	Married	Architect	3 (adult)	"It was very fantastic when I first came ... I waited for the maid to turn up to the house to tidy up ... and my husband said you'd better get up and do it yourself ... they don't have maids here. ... It's a waste of time isn't it if a doctor has to keep on washing up dishes, where she can do with concentration with looking after patients..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
"The whole family is doctors"	"From a very early age, from the age of 4, I wanted nothing except for being a doctor"	Not given	No comment given	(1) women's hospital (2) paediatrics (DCH) (3) to UK after 3 years to do MRCP (paed) (4) subnormality hospital (5) psychiatry (6) 6 months SHO for registration (7) 3 years registrar subnormality hospital (8) GP - because had to keep moving around	Paediatrics

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None	Converted house	Very poor	Two receptionsists (one for morning and one for evening surgery). One cleaner. Use of District Nurse, Midwife, Geriatric Nurse, Paediatric Nurse.	1600	"I do use the deputising service, only for emergency night calls ... alternate weekends, only night calls I give it up to them, day calls I do myself"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... female doctors especially are very sympathetic ... In our country educated women are respected ... and it's much easier to handle there and do the work ... in this country there's not much respect for women"	"Wastage should be prevented ... there should be more creches ... attached to the hospitals"	"I wish I had better patients, a few more, where I can practise just medicine for its own sake, rather than just the social problems"	"I would rather stay here only and finish off ... and retire ... (then) I want to go off somewhere in the warm..."

The experience of general practice

Initially she did some locum work in general practice to get experience, but then decided to go into practice alone. When she started her practice she continued to do some hospital sessions, too. The practice built up fairly quickly. She started by getting about 100 new patients a month. After some time she started having chest pains and so gave up all her hospital sessions but kept on the practice. She had been working about 18 hours a day at the time. She was able to get somebody to cover her rounds for about three months while she got some rest. Since then she had done only her general practice work and had been in practice for 13 years at the time of the interview. She did an occasional locum for somebody else just for the change.

This practice was also a fairly small one, with 1600 patients. She said that she used to have more patients but somebody else started up a practice nearby and she lost some patients to him, although, as she said "it was the troublesome patients"!

Doctor 22 had two receptionists, one for mornings and the other for evenings, and a cleaning woman. She also made use of health authority employed staff: a district nurse, geriatric nurse, paediatric nurse and district midwives and social worker. She used the deputising service, but only for emergency night calls and at weekends, too, she did all her own day calls. She used the deputising service for holidays. The FPC had asked her to become a trainer but she decided it would be too much for her. Doctor 22 did consider taking on an assistant "when the practice was blossoming up", as she put it:

> but then I noticed that whenever they came here, they came here very meek and mild and then suddenly they start trying to run my life for me .... they think that they should take over.

The domestic sphere

Doctor 22's domestic situation was quite different from that of doctor 18 and she had quite different coping strategies. She talked about the culture shock of coming to Britain and finding that she had to cope at home without maids to do all the housework. She had never cooked before and said that:

> (even now) my English cooking is a bit better than my Indian cooking

because a hospital cook had taught her! She said of the housework that "my husband used to help me quite a lot .... tidying up, cleaning up", (accepting in effect that this was her responsibility). She only ever had help when living in hospital flats, when maids came in to clean. A particularly good example of what she had to cope with was when she talked of studying for her DCH (Diploma in Child Health) examinations:

> So many a time I held the feeding bottle to my baby's mouth and a book in the other hand .... most of the meals were burnt!

And when she had to do six months residency in hospital she described how:

> my house was getting in a mess .... there were papers everywhere, the children's toys everywhere.

The children went into a day nursery when young. When her husband left home for three years because of a job elsewhere in the U.K., she had to cope alone. The eldest child was sent to boarding school, while the other two went to a nursery.

It was difficult to elicit much from this doctor about her domestic situation, but an impression was gained of a conventional household, with her having responsibility for the home and childcare, but having paid help at home. She did suggest, though, that she did not see her own arrangements as ideal. She thought that the way life was organised in India was more appropriate for professional women:

> In our country, most of the doctors are married, we have very happy families you see .... we have servants even whether you are practising or not practising .... everybody does you see.

As she went on to say:

> .... it's a waste of time isn't it if a doctor has to keep on washing up dishes, where she can do with concentration on looking after patients.

Attitudes and Aspirations

The attitudes of doctor 22 have already been examined to some extent, but further indications of her views were elicited. For example, on the question of 'wastage', she felt there should be more help given to women so that they can continue to practise medicine:

> (Wastage) .... should be prevented, you know, there should be more creches, things like that, attached to hospitals.

There were other hints at her attitudes when discussing the advantages and disadvantages for women in medicine. She suggested that woman is seen as the "healing woman .... the wise woman" who "have the tendency to help other people, sympathy and understanding". She discussed the problems for women doctors with family commitments of a "rigorous cut down of jobs" particularly for women, and felt that:

> .... in this country there's not much respect for women .... In our country educated women are respected .... and it's so much easier to handle there and do the work.

Doctor 22 also felt that women doctors are better able to help women patients with emotional problems, especially marital problems. She saw this as a special role for married women doctors while "unmarried girls (doctors) are very much equal to the male doctors .... in that their commitments aren't that much". But she realised that women often have commitments, even if single, in a way which most men do not. Another disadvantage she suggested in being a woman doctor is that the relationship with female nurses is often less good than that of the male doctor.

She discussed her main satisfactions and disappointments in her career; her major disappointment lay in having wanted to become a paediatric surgeon, but not doing so, for two reasons:

> It's partly due to my family coming along but mostly due to my health .... But as a doctor, as a female doctor, this country doesn't give that much of a chance.

But she had found satisfaction in general practice because:

> .... in the primary care you can do a lot more for the patient .... to lead a normal healthy life ....

She was happy to remain a GP in her own practice until she retired. She did not envisage changing the practice at all, but would like to continue helping people in the way that being a GP allows.

In contrast to doctor 18, this respondent was much more aware of how women doctors are constrained in their profession by their gender.

A day in the life ....

The premises used by Doctor 22 were a large house in an inner city area with large Asian community, but no-one lived on the premises. They were in stark contrast to the comfortable, homely premises of doctor 18. The glass in the front door of the house was smashed. The waiting room was quite large, with chairs around the edge of the room, broken lino on the floor, shabby, painted walls, with a tiny reception area at one end. There were no toys or books for waiting patients or children. There was a one-bar electric heater. The surgery was also large, with a desk, chairs, an examination couch with curtain at one end, wash-hand basin and a small electric heater. Paint was peeling off the walls in parts and there was broken lino on the floor here, too. The remainder of the house was empty, un-used and in poor condition.

The morning surgery was meant to start at 10a.m. but the doctor arrived from home at 10.15a.m. by which time there were several patients waiting already. She used an appointment system. There were only five patients, quite spaced out between them in the hour of the morning surgery, three of whom spoke different Asian languages - the doctor was able to converse with them in their own languages. At the end of surgery the receptionist came in with repeat prescriptions to sign, and messages. Then two drug company representatives were seen, followed by a coffee break.

We went on one home visit at 12.30p.m.; this was not one where the doctor was called out, but one that was done for my benefit - visiting a 23 day old baby that had been born six weeks premature. Then we had lunch, which she had most days with her husband, but he was away that day. Then she went off shopping and then home to rest.

Evening surgery was between 5p.m. and 6p.m. with eight patients attending. What stood out was the nature of the problems which the patients came in with - these were overwhelmingly social. This was something which the doctor had stressed earlier, when she had said:

> I wish I had better patients .... when I can practise just medicine for its own sake, rather than just the social problems.

There were certainly few physical problems that seemed to warrant a visit to the surgery, but rather minor physical problems that were used as a way to talk about social and emotional problems. The doctor also suggested that many of the Asian women came because this was a reason for getting out of the house.

She said that she would be doing letter writing the following day - probably after morning surgery, but the day had been very typical in showing how the practice ran.

5.3 Doctor 20

A further variation of single-handed practice was shown by the third case study. However, while Doctor 20 was single-handed at the time of the initial interview, she had taken on an assistant by the time the day was spent in her surgery, several months later. It will become clear, though, that her reasons for doing so did not relate to single-handed practice but rather to the financial implications of allowances to general practice.

At 29 this third GP was the youngest of all those interviewed. She was British, having been educated in the Midlands and at Cambridge and then Oxford Universities.

The path to general practice

Doctor 20 had no family connections with medicine, but had gone into medicine because:

> the best job I could think of was medicine .... my family were all working class and we had a family doctor who was a woman and that was the best job I could think of really.

Her main problem at university had been financial. She had had no difficulties academically or in relationships with teaching staff, other

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
29	British	Divorced - cohabiting	1. Drug rep 2. Solicitor	None	"The house is always pretty much of a tip ... my boyfriend does most of the work ... I suppose we have takeaways four or five times (a week) ... or anything that can be cooked in 10 minutes"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors. "My family were all working class"	"When I was little, the best job I could think of was medicine ... and we had a family doctor who was a woman ... and I was good at science"	Not given	"I think I was a bit embarrassed at first (with men patients) but no particular difficulties"	(1) General medicine (2) General surgery (3) Pharmaceutical research (4) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	In child health clinic premises	Good	One practice manager and three part-time receptionists. Use of District Nurse, Midwife.	3,000	"I don't usually finish surgery 'til about 8, and I'm in the area still 'til about 9, so I suppose its most of the evenings, and then every weekend evening, but I do most of my own day calls during the weekends ... I 've got a large list, and I couldn't cope with having to get up at night as well"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"The disadvantages I think are the ones that women have always suffered from, a lot of patients think they can take advantage of women a little easier than men"	"It must be an appalling waste ... a lot of women I went to university with never really had any long-term ambitions to be full-time"	"... it's a satisfaction being my own boss, I mean I can do exactly what I want to do ... I like that aspect of it"	"I hope that as I can build up the private work I can reduce the NHS commitments, and I want to find a partner to do the afternoon surgeries"

students or patients except for being "a bit embarrassed at first". She had intended to go into research in the drug and pharmaceutical industry and did clinical trials for a firm at an early stage in her career. (Her husband, whom she had married while she was still a student, was a project manager for one of the firms.) She had been offered one or two positions in research in that area but decided against it, because it would have involved a lot of travelling which would have kept her away from home where she had a small business[3] which entailed a considerable amount of commitment. And as she said:

> .... when I thought about it I realised that with the pay structure and the uncertainty of the .... position in the pharmaceutical world at that time, I would really almost be better off in general practice and followed my own inclination here, which is what I wanted to do.

So at the end of her university training she did the standard two house jobs in medicine and surgery in a large Midlands city.

The experience of general practice

She decided to go straight into general practice and so followed the one year vocational training scheme. This was in a practice of seven, split into a group of four and a group of three. She worked in very much a junior capacity, so that:

> you just do the work that's given to you.

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3 This was not medically related.

She thought of it as marking time "while I found the practice where I wanted to go".

By the end of the trainee year she was also working for the deputising service and intended to do so full-time to earn some money. However, she was offered a salaried partnership in a practice which she accepted "to get the year's experience I needed for single-handed practice". She was working with a man in this practice and described it as:

> just a standard general practice, run sort of as a business .... to make money, that was the attitude, you know, you look after the patients but it was to make money .... it was looked on as a sort of livelihood rather than just done for the good of the patients ....

She did not think that women patients came particularly to see her rather than the male doctor, because they would swop round surgeries so that patients did not know who they would be seeing - this was done to fit in with the deputising she was still doing.

After a year in that practice Doctor 20 did some locums for a couple of months until joining the present practice. She originally had a male partner who died, and a part-time woman partner, but the practice was split between herself and the woman after her partner's death. After working together for a short while, they had both become single-handed, having divided the practice between them.

Doctor 20's practice was by far the biggest in the three case studies, with 3,000 patients. It was also one of the biggest of the whole sample. The

practice was situated in premises shared with a child-baby clinic in the surburbs of a large city, so that the accommodation was rented from the health authority on a temporary basis. The doctor was in fact in the process of buying a house from which to run the practice very close by. She had a practice-manager and three part-time receptionists, plus attached health authority district nurse and midwife. She used the deputising service after 9p.m. in the evenings, including weekend evenings, but did her own day calls at weekends. She justified this by saying:

> I mean I have long working days .... I've got a large list, and I couldn't cope with having to get up at night as well.

This doctor made it clear that she did not like going out at night, because she felt at risk as a woman, and this was one reason why she had given up working for the deputising service:

> I used to do a lot of deputising, mainly on my own, or with a friend driving me around, but it does get very nasty at night, and although this is quite a select area, the select areas are the worst ones you find to go around in.

She liked general practice because of its versatility and also found that it gave her time:

> .... to do the things I want to do out of hours, and then being single-handed, my time's completely my own, I can have the staff do chores that I want them to do, I can organise my surgeries to suit myself, it just fits in beautifully.

But, she had been unprepared for "the petty aggravations which are the main thing that spoil it for me". As she went on to explain:

> .... it's all the little things, the way people are so rude to you .... and because they consider it all public property, there's no particular shame on their part, they'll sit down and vandalise the chairs or whatever .... and this is a very nice area. And the way they speak to the staff and to me at times I think's appalling, and it's not something that anyone else who works in a professional capacity has to put up with, it's really only doctors, because you've got no back answer quickly to them .... that spoils a lot of the work for me.

She felt the answer for her was to build up a private list and cut down the NHS patients as quickly as she could. She already had some private patients whom she saw either at her home or in their own homes.

The domestic sphere

In looking at her domestic life, it quickly becomes evident that Doctor 22 was in quite a different situation from doctors 18 and 22. She had divorced after two years of marriage and lived with her boyfriend. She said that he did most of the work in the house:

> He'll always clean up if the house is a tip. And he'll always wash up. He's quite well trained.

They rarely cooked - eating take-aways four or five times a week:

> .... or anything that can be cooked in ten minutes ... I try to get my mother to do my washing and ironing but ... she doesn't always agree ....

It became evident that the domestic side of her life did not interfere with her professional life. There were no children to have responsibility for nor

did she intend having any in the future. Apart from general practice work, her responsibilities lay with the small business which she ran from her home.

Attitudes and Aspirations

She viewed general practice as a very suitable set up for women - particularly if they wanted to work part-time, to fit in a family with the flexibility of surgeries.

> So I think it suits a lot of women from the point of view of the hours and as far as women's pay is concerned of course, women get as much pay as men. And since part-time of 20 hours is equivalent for full-time as far as the government allowances go, it's very good money for a woman in general I think.[4]

The disadvantages for women in medicine were:

> .... (the same as) the ones that women have always suffered from, a lot of patients think they can take advantage of women a little easier than men. I think it's harder to control your staff when you're a woman, mainly because you make friends with them rather than just treat them as employees.

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4 As indicated above, by the time of the second visit to her surgery she had taken on an assistant. This meant that they worked 20 hours a week each and got two lots of allowances. She was able to pay the assistant all her allowances (which was good pay for an assistant) and have exactly the same money herself but for half the number of hours, with the same autonomy within the practice. She would have preferred to remain completely single-handed but felt that she would have been foolish to work double the hours she needed for the same financial outcome.

But she did see some advantage to the patients in having a woman GP, but felt that this also meant she was taken advantage of:

> I think the patients talk too much to women, I often find that they'll sit here and they'll talk to me over things I know jolly well they wouldn't feel free just to bring up what they want to a gentleman. To some extent it's nice because it means that the patients will talk to you more freely and tell you problems earlier. On the other hand it's a nuisance when people just sit there chatting to you .... but I quite like that aspect, I'm quite casual in my approach to patients so if they want to consider you as their friend, it usually means that things are going well. You don't have to worry too much about the rest of the medicine that's going on.

She felt that, in quite a few families, the women and children came to see her while the husband went elsewhere. This became pretty obvious when her male partner died. But she also thought that others changed because she had a foreign sounding name and some patients "weren't sure whether I was white or not".[5]

She talked about disappointments in her career and was very dissatisfied at the amount of work she was expected to do:

> .... there's never any end to the demand of general practice, and the more you do, and the more proper medicine you do, the longer and more difficult you make the job. There's no going back, once you've .... started to examine patients properly, you can't sort of cut down and get them in and out quickly, and I find that that's very tedious the way the day extends.

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5 All patients attending on the day the practice was observed were white.

She did not run an appointment system because she felt it was in the patients' best interests to be able to attend the surgery when they wanted to, although she did feel it would be in her own interest, because evening surgery always ran well over time:

> .... every day just before 6 o'clock we get four or five rush in just to be late and those sort of aggravations .... ruin the day and make the day very long.

She talked further of her frustration at the way patients treated her and the service provided:

> When I'm on call for emergencies at weekends, I don't really expect to have to go and see sore throats, coughs and colds over the weekends, but when people phone and say they want you to visit for various things, you haven't really got any way of getting out of it, and the frustrations that causes and the interruption in your home life far outweighs any advantage that there could possibly be to the patient

But she also found general practice very satisfying:

> .... firstly making friends with all the patients .... and you actually go into people's homes and see the way people live, the way they behave ....

And later:

> .... it's nice to make the right diagnoses sometimes. When you're in hospital you always see patients second-hand, there's somebody already seen them and may have some idea of what's wrong with them and it's quite interesting I find to sort out the rubbish from the important things and then when you have the satisfaction of following something all the way through and making a diagnosis before you send them off to hospital, I think that's very nice.

Doctor 20 also liked seeing the babies she had delivered starting to grow up and she had already seen quite a few in the short time (two years) she had been in the practice. But the greatest satisfaction of single-handed practice had been:

> .... being my own boss, I mean I can do exactly what I want to do, to some extent anyway, I like that .... I like that aspect to it.

The question of "wastage", she found "appalling", but:

> .... a lot of women I went to University with never really had any long term ambitions to be full-time but I suppose with the current trend to everybody working part-time, it'll probably even itself out.

Her ambitions for the future were different from any other GP interviewed. She wanted to build up the private work and reduce the NHS commitments, and at the initial interview she wanted "to find a partner to do the afternoon surgeries, and then myself take advantage of this 20 hour week being full-time". As mentioned earlier, she had already taken this step by the time of the second meeting with her.

A day in the life ....

The day spent in the surgery with this doctor was described by her as being very typical of how her practice had been when she had been completely single-handed. Now, it was the only day in the week when she worked for a whole day, so that it consisted of morning and evening surgeries, as well as an ante-natal/child and baby clinic in the afternoon.

The building in which the surgery was situated was normally used as a clinic for GPs in the area to run their child-baby sessions. It was situated in a busy shopping centre. The large waiting area was carpeted, with chairs around the edge and was shared with the other baby clinics. There were separate reception areas for the GP and for the other baby clinics. There were magazines for waiting patients and toys for children in the waiting area. The surgery itself was fairly small with desk, wash-hand basin, trolley with instruments, examination couch and screen, and heater and toilet off the surgery. It was thus well-provided for in terms of facilities.

The morning surgery began at 9.30a.m. and ended at 11a.m. in which time eleven patients were seen. Then after a short coffee break, during which time the doctor signed repeat prescriptions, letters and so on, she did a medical on a company employee. She had an arrangement with several different companies to do employee medical checks and did this as an extra source of income for very little effort on her part. She then saw a staff patient (receptionist) and then a drug company representative.

An hour was then taken over lunch, followed by two home visits and a third - where the patient was not at home when we called! On returning to the surgery the ante-natal/baby clinic commenced immediately at 2.40p.m. lasting until 4.15p.m. She saw two pregnant mothers, for which the midwife was in attendance, three babies for injections (which she let the nurse do, because she preferred the babies and children not to have a reason to be frightened of her) and also five children.

A short tea break was followed by evening surgery which lasted from 4.30 to 6.30p.m. She saw twelve patients in that time. None of the patients who came appeared to have anything seriously wrong with them, they were attending mainly for coughs, colds, ear infections and back pain. There were only one or two obvious emotional problems.

There is little question that, in comparing this doctor's day with those of the other two case studies, that this last one was very much busier. This is hardly surprising, though, since she had double the number of patients on her list. Despite seeing so many more patients in the time, she also seemed to take much more time to explain to patients about treatment, diagnosis and so on. Of course, it was not possible to know to what extent this was the usual course of action when no observer was present, but the impression gained was that this was her usual practice. There was a friendly and fairly relaxed atmosphere within the practice.

The following chapters use these case studies and material from the interviews with the other 26 doctors to analyse seven different areas of the experience and practice of the single-handed woman GP. The following matters are discussed: the path to general practice (chapter 6); the experience of general practice (chapter 7); general practice premises and the primary health care team (chapter 8); out-of-hours cover (chapter 9); general practitioners at home (chapter 10); attitudes and aspirations (chapter 11); and ethnicity (chapter 12).

CHAPTER SIX

THE PATH TO GENERAL PRACTICE

This chapter traces the path taken through to the time when the women interviewed first became general practitioners. It starts by examining the influences which made them choose medicine as a career. It then follows them from entry into medical school, through their training, and continues throughout the hospital career. By so doing, the reasons for them deciding to become general practitioners becomes the final focus of the chapter.

By following this path through the training and early careers of the single-handed women doctors it is possible to trace a pattern of decisions, choices, constraints and actions which led them to general practice, and as related in chapter 7, into single-handed general practice. In chapter 2 several issues were examined which showed that, historically, the path of women in medicine has been anything but smooth. Male prejudices, discrimination and obstruction have served to limit the achievements of women within medicine, in terms of both medical undergraduate training and postgraduate training and in their subsequent careers. For example, in chapter 2, the history of women's acceptance into medical schools up to their present level of 44 per cent (1986 figure) is briefly examined and explained. Postgraduate training is discussed too, along with the need for more part-time training. It is difficult to divorce the issue of training from career progression since training is an intrinsic part of the career ladder to consultant level. However, the way doctors' careers are structured is crucially related to the choice of specialism that they follow, and there is

discussion of how gender affects such 'choices' at all levels. As indicated in chapter 2, 'choice' or the exercise of personal preference is not the main factor determining where women (or men) work (Elston, 1977; 1980). Consequently, women are best represented in the less popular, less highly 'skilled', 'shortage' or under-financed specialties, rather than the technological and surgical specialisms, particularly at consultant levels.

The women GPs in this study are examples of doctors who have 'chosen' not to pursue hospital careers, either at all, or beyond a certain point. They have, in effect, failed to 'beat the system' and succeed in medical terms by progressing to the level of consultant in the specialism of their choice. In a sense, they had 'given up' and gone into general practice. But, by looking more closely at the pattern of their training and career experiences, gender-specific constraints can be seen to be operating to channel them in certain directions, and to make the use of the term 'failure' redundant. In addition, nearly all of them had some experience of gender-related discrimination or there were aspects of their experience which had been affected in a gender-related way.

The age range (29-68) of the GPs adds a further interesting dimension, as many of their experiences can be matched in time to the increased movement of women into the medical profession in the last 40 years discussed in chapter 2. The younger women doctors had constituted a larger percentage of medical students when they did their medical training, because women were by that time being accepted into the profession in greater numbers. The older women doctors, however, had been a much smaller group in medical school and this has some consequences for differences in experiences and attitudes. Aspects of their experiences which are related to ethnicity are also significant, and considered in chapter 12.

Table 6.1

PERSONAL DETAILS OF THE 29 WOMEN GPs

Doctor	Age	Ethnic origin	Marital status	Children and ages
1	52	Asian (India)	Widow	5 (all adult)
2	49	Asian (India)	Married	4 (16-2)
3	67	British	Single	None
4	34	British	Married	1 (3)
5	37	Asian (Sri Lanka)	Married	4 (14-7)
6	50	British	Married	3 (26-15)
7	31	British	Married	1 (15 months)
8	53	British	Married	3 (23, 20, 18)
9	38	British	Married	2 (10, 5)
10	40	Asian (India)	Married	2 (14,9)
11	44	Asian (India)	Married	2 (18, 15)
12	47	Eire	Married	2 (21, 19)
13	44	Asian (Pakistan)	Single	None
14	45	British	Married	2 stepchildren (21, 19)
15	41	Asian (India)	Married	2 (7, 4)
16	59	British	Married	3 (all adult)
17	68	East European	Widow	1 (adult)
18	46	British (Chinese)	Separated	4 (2 adult and 21, 19)
19	44	Asian (India)	Married	2 (13, 10)
20	29	British	Divorced -cohabiting	None
21	48	British	Married	8 (7 adult, 12)
22	52	Asian (India)	Married	3 (all adult)
23	49	British	Divorced	2 (all adult)
24	50	Asian (India)	Widow	3 (all adult)
25	32	British	Married	2 ($2\frac{1}{2}$, 4 months)
26	68	British	Single	4 (all adult)
27	49	Asian (India)	Married	3 (20, 18, 14)
28	54	British	Separated	5 (3 adults, twins 17)
29	65	British	Married	4 (all adult)

The ages and ethnic origins of the GPs, along with details of marital status and children are given in Table 6.1. These personal details contribute to an understanding of the women GPs' backgrounds before presentation of the main body of the data.

This chapter, therefore, will follow the women doctors through their careers until they become general practitioners. Many of the factors discussed below are relevant to women in medicine generally, but it will become clear how these early experiences have contributed to decisions made at later stages of their lives, since 'choices' are made on the basis of cumulative experience. These, then, are the varied experiences of women doctors who have all gone on to become single-handed GPs.

6.1 Why go into medicine?

The decision to pursue a medical career was taken for a range of reasons, as a result of different influences (see Table 6.2). It is often suggested that medical students follow parents (particularly fathers) and other family members into medicine. In fact some medical schools favour applicants from medical families over better-qualified ones from non-medical families. This is because, it is claimed, medicine is a very demanding career and to be brought up in a medical family will give an insight into its stresses and demands. Living in a medical atmosphere can be seen to have a profound effect on the choice of a medical career, and indeed on the shape and direction of that career. In this research there were examples of women who came from such families, who felt that their background had shaped their choice of a career in medicine. In fact four of the women came from medical families - two felt that this had definitely influenced their decisions to be doctors, while the other two were less convinced of this. Doctor 21 was sure that her father had influenced her decision to study medicine:

> I was very young when I decided .... I suppose my father being a doctor, and I admired him, and liked .... yes, I'm sure that's what made me decide. (no 21)

Doctor 25, however, both of whose parents were doctors, was less convinced that her medical family background had influenced her:

> Well, it shouldn't have been, they didn't .... I mean in the sense that I didn't have that much experience of it from them, they didn t bring it home, they didn't encourage me to do medicine .... (no 25)

Table 6.2 **Reasons for choosing a medical career**

REASON	NO	DOCTOR
Family influence		
Doctor parents	4	21, 22, 23, 25
Other medical family members	5	7, 10, 13, 15, 17
Non-medical parents' influence	4	6, 13, 14, 19
Wanted from early age	11	2, 9, 11, 14, 15, 16, 18, 21, 22, 26, 29
To be with/help people	5	1, 5, 10, 17, 20
Good at sciences	5	3, 4, 20, 27, 28
Sense of vocation	2	8, 24
Gives you freedom and respect	1	12

(Some doctors appear in more than one category)

Other ing a medical family background, did feel that they had arents in their decision to become doctors (4 cases).

However, for 5 of the women some influence was forthcoming from other family members who were doctors or medical students - uncles, cousins, brothers, sisters and so on. For the remaining doctors, where there were no family connections with medicine at all, and where non-medical parents had not steered them towards medicine, respondents were less clear about why they had become doctors. The sorts of general reasons given were 'to be with people', 'always wanted it from very young age' and 'good at science', but there was little discussion of medicine as a vocation, rather it was an idea which had come to fruition with little real planning.[1] Only two doctors saw medicine as fulfilling a sense of vocation. For example:

> I felt called to the missionary service .... that was quite definitely a sense of vocation .... I went into medicine with the idea of being a medical missionary. (no 8)

And another:

> My husband died very young, and I wanted to do the work he would have done if he was alive .... I wanted to do all the work that he couldn't because he died very young. (no 24)

However, as will be suggested in chapter 12, amongst the Asian doctors in the sample were those who had chosen medicine because it is viewed (in the words of doctor 10) as "a good line for ladies", due to cultural norms surrounding sex-segregation which give women a particular role in medicine, i.e. to specialise in obstetrics and gynaecology.

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1 These reasons were given by some of those with family influences too (see Table 6.2).

Once the decision to become a doctor has been made there are a number of forces throughout the career which give it its shape, especially for women. Entry into, and experiences within medical school have an important part to play.

6.2 Medical Training

In looking at the medical training of the women GPs it is possible to identify in their experiences examples of gender related difficulties in both academic and clinical work, also in their relationships with other students, teaching staff and patients. Three of the women trained in women-only medical schools - one in India, and the other two at the Royal Free in London (no longer for women only). These two were probably contemporaries since they were quite close in age. The rest of the women were at mixed medical schools where they made up a smaller percentage of the students than did men. As shown in Table 6.3, women made up between 8 and 50 per cent of students in their year: 9 had 15 per cent or under; 7 had 20 - 30 per cent; and one had 50 per cent women (the rest, 9, did not state a percentage).[2] The younger women, not surprisingly, reported more female peers in medical school than the older ones. The three who trained in women only schools were aged 44 and above (indeed, the two British trained ones were both in their fifties and this reflects a change in

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2 These percentages are based on respondents' estimates.

Table 6.3 **Respondents' estimates of percentages of women in medical school**

PERCENTAGE	NO	DOCTOR
All women	3	10, 16, 28
50	1	15
20-30	7	4, 5, 7, 9, 14, 17, 25
15 or under	9	3, 8, 12, 13, 19, 23, 24, 26, 27

policy over single-sex training in medical schools after the 1944 Goodenough Report). Attitudes amongst the women as to whether they felt that the proportion of women on their course was large or small are revealing. The younger ones (under 40, but with the larger proportion) felt that the percentage of women was small, while the older ones (with the smaller proportion) tended to feel that percentages were large. This implies both a change in attitude and expectations by the women themselves and generally about women in medicine.[3]

There were a number of examples of difficulties experienced as medical students which were gender related. For example, respondents felt that it was more difficult for women to get into medical school than men, and that those who did get in were more highly qualified:

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3 See chapter 11 for discussion of respondents' attitudes to women in medicine.

> I had difficulties getting in in the first place .... and we had to have very much higher standards of education than the boys to get in .... (no 14)

> I had more problem relating to my fellow students because I had a chip having had to wait a year to get in. There were a lot of men who had lower grades than me .... (no 4)

> .... the girls tended to have to get higher grades than the boys, which was interesting .... (no 7)

Some of the academic difficulties can be seen to be gender-related too. For instance, one woman (now aged 68) started medical school with no science background at all (she would have been at school at a time when there was considerably less encouragement for girls to do science) and found this difficult to deal with because as a female it made her stand out:

> I was made to look a fool, because don't forget the women were very very much outnumbered in those days. (no 26)

There were other academic difficulties which were closely linked to the attitudes of and treatment by staff and lecturers. As one woman said:

> .... my surgery professor was very anti-women, and I had great difficulty with him trying to get through my finals, because he .... used to produce very difficult cases all along for me, particularly for the women .... and there was also another man who was .... a gynae man - thoroughly disliked women, his attitude was that they ought to be at home and nowhere else at all, and I would probably have failed my gynae and obstetrics, but for the fact that I was already married .... (no 12)

Other staff treated women students differently too:

> .... they thought we were all men ... and you were very much the poor relation .... unless you were very attractive and, you know, prepared to use your women's wiles a bit .... oh dear that first year was absolute slavery, it really was. (no 26)[4]

Three of the women had had babies while still medical students. One (no 18) had not found this to be a problem at all, and had three children as a student without losing any time or failing any exams. The other two, however, fared less well. Doctor 21 had three children too before qualifying which held her back a year, since she failed surgery first time round. Doctor 6 had a child just as she was doing finals and failed some exams at the time. As she said:

> I resat my finals which was ... quite a trauma .... I had six months to wait to resit and I was breast feeding this baby .... then I went back up to sit this exam, and there was this baby in a pram .... nobody had ever seen anything like it before! .... it was very difficult. (no 6)

Since the maximum amount that any of the respondents had been held back at the training stage through having children was one year, it is apparent that from these very earliest stages they were a highly motivated group. This has implications for the later analyses on being single-handed GPs, because it will become clear that this strong motivation led them to seek control over their own practice of medicine.[5]

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4 The respondents' experiences revealed a male culture in medical school comparable with that discussed by Becker (1961).

5 It also implies that the extent to which these women allowed certain of their domestic responsibilities to affect their careers at all stages was less than those in control of those careers would have us believe.

There were other problems, as in relationships with patients. Two of the respondents suggested that women medical students were often viewed differently from the men, because of the male image of medicine:

> I suppose to some extent because they (men patients) weren't very used to having .... women about .... they always assumed that if we were women we were nurses .... they were not quite used to what to do with women. (no 23)

> Some of the patients had problems associating the fact that you were a medical student or later on when you were a doctor .... I mean, they automatically thought because you were a girl you were a nurse .... in spite of you having your name badge which said that you were a medical student. (no 7)

There is little doubt that this sort of response from patients is likely to be disturbing and undermining at a time when, as medical students, women are in any case feeling uncertain and lacking in confidence about their abilities. However, these are assumptions and attitudes which women may encounter as a challenge to their authority throughout their medical career.

An extreme example of a male patient's reaction to a woman medical student came from a woman who had trained in India:

> Some (men) would not let us examine them unless we have a male student with us .... (no 24)

However, some women had other difficulties when treating male patients, particularly those from the women-only medical schools:

> I was very shy. I was an only child, I had no father, no brothers .... I had been to a girl's school .... for five years, that (medical school) was all just women .... so it was difficult and I was

> terrified, you're suddenly presented with a man patient, you examine them as far as the waist and you just daren't, you know, terrible. Had to put a brave face on and hope for the best. (no 16)

Others too had similar difficulties though:

> I was a bit naive about life, I mean I was brought up in a convent, terribly sheltered and I mean I had no clue about a man patient except I must be honest .... until my second clinical year I got away without examining a male patient .... it was hard manipulation work, but I managed to do that and then I thought to myself, crikey, that's ridiculous, you know, you have to .... (no 15)

For most of the women, seeing patients was the most interesting part of their medical training. While some reported difficulties as medical students on the wards, and in relating to patients, staff and each other, it is probable that some of these difficulties were common to many other students, and not all gender-related. There were, of course, many common positive parts to the training. As one woman said of her initial experiences of the clinical training:

> I liked that very much really, because after .... two years of having to dissect the human body and studying about the human body .... after two years you go into the hospitals and see the patients, and really we were all looking forward (to it) .... (no 5)

Despite examples of gender-related problems during training, for the most part the women saw their time at medical school as a positive experience. It was their initial attempts to work as doctors which proved to be a shock and where many felt that they had experienced discrimination and unfair practice - in competition for jobs with men, or through the attitudes of

senior colleagues. They also experienced pressures to conform to stereotypical "women's" roles. These are all factors which cumulatively would contribute to these women becoming single-handed GPs in the future.

6.3 From new doctor to GP - the hospital career

Immediately post-qualification, there is a requirement for medical graduates to complete two six month house jobs in order to gain registration as doctors. Gaining the 'right' jobs and experience is important for the future career, from this very earliest stage. This has been recognised in studies of other professions (e.g. Podmore and Spencer, 1982 on the law) as well as in medicine (Becker, 1961). The 'right sort of background, and involvement in the 'appropriate' sorts of activities are crucially important at this stage. One woman commented:

> .... at that time the old school tie, you know, daddy's a consultant, you know this sort of thing, I felt there was a little bit of that, and if you were in the University rugby team you'd get a good house job. (no 14)

Involvement in 'appropriate' activities is clearly something that is less likely for women than men. Whilst women may equally come from a medical or professional family (see Elston, 1977; 1980) they are less likely to have the 'right' school tie, and even less likely to be involved in sporting activities such as rugby, which include meeting and cultivating sponsors in clubs, changing rooms and bars. It is not only the fact that the 'appropriate' sports tend to be those which are played by men, but also that such activities often take place at times when women are likely to have

other responsibilities to cope with (such as families and so on). This is something which takes place throughout the professional career, but is especially important at the earliest beginnings of that career.[6]

There now follows a discussion of the choices of specialism the women doctors took during the hospital career and these can be followed through over time by referring to Table 6.4. In applying for house jobs the women doctors displayed two sorts of motives. There were those who, from the outset, had ideas about a chosen hospital specialism they wished to follow in later career, and there were those who were attempting to gain as wide an experience as possible, either because they had not yet decided which specialism to follow or because they wanted a wide experience to qualify them for general practice.

Over a third (13) of the women knew at the outset which specialism they wished to follow, and set about trying to gain appropriate experience.[7] Of the 13, six wanted to specialise in obstetrics and gynaecology, and this

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6 As has been suggested, these considerations apply to professions other than medicine. In the medical context, see Lorber, 1975, 1984; Elston, 1977, 1980; Epstein 1970; and Hall 1948; also see chapter 2, especially footnote 5, See also Nadelson (1983) on 'role models' in medicine.

7 Some never worked at all in the specialism they originally wanted. As Lorber (1984:33) says "... men are apt to follow their career choices: ... women are not."

Table 6.4 **Choices of Specialism**

(Doctors shown in brackets)

Chosen specialism known at outset	No specialism in view	Always wanted GP
13	9	7
		(3, 7, 9, 15, 16, 18, 21)
obs/gynae 6 (1, 10 11, 13, 19, 26)	community health 4(6, 23, 27, 28)	
paediatrics 2 (22, 25)	drifted into GP 5(2, 4, 12, 17, 29)	
general surgery 2 (14, 24)		
ophthalmology 1 (5)		
pharmaceutical research 1 (20)		
medical missionary 1 (8)		

was by far the most popular specialism. Attempts to do so, however, were only successful up to a point. Even the doctor with many years experience in this area realised she would not be able to get a consultant post and therefore changed her direction to become a GP. Five of the six were Asian and this is to be expected because of the cultural norms of sex-segregation (see chapter 12). British women are less likely to pick this as a specialism, whether they are interested to pursue it or not, since they know that its male-dominated nature makes achievement within it difficult for women.[8] Other specialisms which were pursued for a short or longer period

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8 This male domination of obstetrics and gynaecology has been demonstrated by the recent Wendy Savage case (Savage, 1986).

of time were paediatrics (2), general surgery (2), and ophthalmology (1). In addition, one doctor pursued pharmaceutical research trials (no 20), and another became a medical missionary (no 8). Until a doctor reaches the level of consultant in a specialism, it is necessary to take a series of short-term appointments which are insecure. The uncertainty of that situation, the constant moving around the country which may be involved, potentially being separated from husbands and the uprooting of children from schools, were common reasons for giving up ambitions for a hospital specialism. For example:

> My little boy was 3 years old and my older one was 6 years, and my job in hospital, even though I enjoyed very much the job itself, but it was very strenuous job to work day and night when you're on duty, and I found it very difficult to look after the children, sometimes I have to leave them with nurses and so on, and I found life was extremely difficult for me, so we decided we would try in general practice job. (no 11)

> .... just when I finished (FRCS) then I got into general practice, because of the children really, because I didn't want them moving around .... just when they were getting into schools and getting into classes and it's difficult to move them from place to place. (no 5)

There were other reasons for giving up in their chosen specialism (and also a specialism which had not been specifically chosen at the outset but which circumstances had led them into - for example, doctor no 14 had wanted to specialise in general surgery but had done rheumatology because back trouble had meant she could not stand for the long periods of time necessary in surgery). Some said they had not been successful in postgraduate examinations, or that they did not want to do any more of them. Some of the Asian woman found themselves having to repeat certain

areas of experience already gained, when they came to the UK (see chapter 12) and, rather than repeatedly working at junior levels in hospital medicine, this led them into general practice.

Those who had no particular specialism in view on qualification (9) had varied experience. Four of them worked in community health (school medicals, baby clinics, family planning and so on) mainly on a part-time sessional basis to fit in with domestic and child care commitments. One had done this for as many as 23 years (no 28). Another (no 23) had done so for 10 years until she felt able to commit enough time to general practice, which was what she had wanted all along - community health had been an expedient.[9,10]

The other five of the women who from the outset had had no particular specialism in view had 'drifted' into general practice, either because it had seemed the easiest option to match their domestic circumstances, or because of the difficulties of achieving any status in any of the specialisms in which they had worked. It is noticeable that, inevitably, many of those women who had had a particular specialism in view at the outset, had had to give this up at an early stage - circumstances had pushed them into other specialisms, or a variety of specialisms. Given that, there was considerable overlap between these two groups. Both groups included

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9 Women doctors often choose community health or other forms of part-time medical work rather than the Doctors' Retainer Scheme at this difficult time in their lives. See Chapter 3.

10 The figure of 60 per cent of those working in community health being women disguises, the number of those who are doing it in conjunction with other things, such as, for example, general practice (e.g. many GPs run sessions such as Family Planning Clinic sessions).

women who had not been able to develop their career in a particular specialism and so had worked in several of them (at junior levels). They found after some time that this varied experience seemed to qualify them well for general practice. Hence they had taken this option, perhaps once the decision was made, going about getting any further experience which would make them even more suited to general practice. As one woman's experience shows:

> I did some paediatrics .... I didn't know what I was going to do, but I enjoyed paediatrics, and I enjoyed psychiatry and I thought I might stay in either of those, ... but I decided .... I didn't think I'd be able to stand psychiatry 100 per cent for the rest of my life .... so I thought I'd have another go at some paediatrics .... and it was during that time that I thought I'd probably be happier doing general practice in fact. .... And then I did 6 months obstetrics .... on the way to general practice, and then I did my trainee year for general practice. (no 25)

Another said that:

> I did quite a few house jobs .... the first one was surgery, then I did a paediatric one .... and after that .... brain surgery, and a six months job in ear, nose and throat. Then I want into general practice .... and then I went to do my gynae and obstetrics. (no 12)

There were another group of respondents (7) who had wanted general practice from the start or from a very early stage, and depending mostly on their age, either went straight into it on qualification (the older ones) or set about getting suitable experience or doing vocational training (the younger ones). For example, doctor no 16 (aged 59 at the time of interview):

> .... I didn't want to do any hospital work when I qualified,so that meant general practice .... you didn't have to (do any house jobs) in those days. The minute you qualified that was it. (no 16)

Doctor no 3 (aged 67) had also decided on general practice:

> I think I spent two years in hospital .... (but) I decided when I qualified .... I was always going to come into a country practice .... so that I decided that originally .... and this is ideal. (no 3)

However, later generations of doctors had to do a certain number of house jobs and gain hospital experience in order to get full registration as doctors. Doctor no 15 (aged 41) was very instrumental in the management of her career experience:

> I did 6 months medicine, 6 months surgery, 6 months casualty, and I still hadn't enough surgical, and I wanted to do a surgical job because I wanted to be a GP .... I mean I knew what I wanted to do, and I wanted to do all the jobs, so that if ever I went into practice, I'd have done them. (no 15)

The women GPs, therefore, had come to general practice by a number of paths. The career paths they described confirm a number of theories and help in an understanding of the circumstances which led to the decision to become general practitioners. It is important to acknowledge that although the choice to become GPs was taken at different points in their careers and at different lengths of time after qualification, most viewed their decision at the time they had taken it (and subsequently) as a positive one. However, it must also be acknowledged that such decisions were influenced to a large extent by events. Decisions were not always based on one factor but several, or a series of interrelated factors, and these must be

considered in analysis. It has been suggested by Elston (1980), Rhodes (1983(a)) and others that the choice to become a GP is often related to marital status (see chapter 2) and this was a point made by many of the women in this study.[11] As doctor no 27 responded when asked if she had become a GP because she was married:

> Yes .... otherwise I would have continued in general surgery. (no 27)

The combination of marriage, children and the resulting domestic responsibilities had a very strong influence on the decision to become GPs and in some cases, to go into partnership with husbands. There were two examples, however, of GPs who had not wanted to go into general practice at all. They had resented the fact that they had been steered in that direction. Doctor 11 explained this:

> Workwise I was more satisfied when I was working in hospital .... and I never ever wanted to be a general practitioner, when I was in hospital, but unfortunately because of my .... family problems, I became a general practitioner not very happily. .... I don't regret (it) now, I like general practice very much now, and .... I'm quite happy with my practice. (no 11)

The difficulties engendered by following a hospital career in a particular specialty are several. Because of the male-dominated nature of many of the specialties (and indeed medicine per se), there were problems related to trying to succeed as women. This was particularly the case in surgical specialties. Such problems came in the form of obtaining such posts in the

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11 This is often the case for men too.

first place, gaining promotion within them, and the adverse treatment and responses of colleagues, peers and superiors in the male culture. When following a hospital career,[12] most non-consultant posts are short-term (the more junior they are, the more short-term) and may be for as little as 6 months at a time. The necessity of taking a series of posts of 6 months or 1 year duration, which may involve moving to another part of the country, is very disruptive. Doctors who are married are not keen to be parted from their husbands, and if there are children involved too, this disruption may be unmanageable. With the vast majority of those who were married having professional husbands this could seem unresolvable (since the man's profession took precedence over the woman's), particularly where the husbands were doctors too. In any case, compromise to deal with such situations often took the form of opting for general practice (in some cases for both husband and wife). Some of the GPs did live apart from their families and certainly from their husbands for considerable lengths of time (doctor no 22 for 3 years), only seeing each other at weekends or when off-duty. Many found such situations intolerable and unworkable from the point of view of family life. Often, it was the disruption to children rather than husbands which forced the decision to make what were viewed as career compromises. In such cases, frequently changing children's schools with each move, caused all sorts of problems. In addition, moving around the country from job to job can limit access to any support networks, particularly parents and other relatives who are not around to be called on for babysitting and helping with child care and giving support in a host of

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12 The term career itself implies a traditional male lifestyle with no deviations from the 'goal' of reaching its highest levels. The medical profession, like many other professions, is organised around the male lifestyle. See Hochschild (1975) on this.

different ways. The interaction of professional and domestic lives is discussed in detail in chapters 9 and 10, but it is evident here that this interaction occurs at all stages of life and career and is crucial to the choices and decisions women make, such as those of these women GPs to practise single-handed.

As shown in chapter 2, the decision to go into general practice is often the result of compromise[13] but, as the data in this chapter show, those for whom this was not their first choice of specialism saw general practice as a **positive** alternative. Not only did they envisage that it would be easier to reconcile with domestic commitments (although difficulties of this nature are discussed in chapter 10), but they viewed the type of medicine which they would be practising in a positive light. They could also envisage within it the opportunity to pursue some aspects of medical practice which had seemed to be closed to them in hospital medicine, in male-dominated specialisms (e.g. obstetrics and gynaecology). However, the decision to be GPs was positive - wanting to practise a more broad-based type of medicine, which would give them a wider range of experience. Often, too, they were reacting against previous experiences of over-specialisation. As explained by doctor 12:

> .... during my ENT job, towards the end of it, I was very fed up doing the same thing over and over again .... (and) a pretty depressing job was my brain surgery job .... probably because it

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13 Nadelson states that the conflicting demands of family and career "lead women to choose less intensely involving, more flexible pursuits and to compromise their plans for specialty certification and career development. Women often choose fields or pursue paths for pragmatic reasons rather than because of true interest or talent" (1983: 268).

> was the same thing over and over again .... and I thought of general practice. (no 12)

This chapter has explored the decision to pursue a medical career, the experience of medical training, the practice of hospital medicine and the route to general practice. It is evident that many of the choices and decisions made at various stages of the medical career are influenced by gender - experiences which are peculiar to women medical students and doctors. Once the decision to become GPs has been taken, doctors have many different expectations of what general practice will be like. However, in the case of these GPs not all their expectations were fulfilled in terms of their initial experiences of general practice. Chapter 7 considers respondents' experiences of general practice which led them in the short or long run to opt for single-handed practice.

CHAPTER SEVEN

THE EXPERIENCE OF GENERAL PRACTICE - THE ATTRACTIONS OF WORKING SINGLE-HANDED

Since the last chapter concluded at the point of entry to general practice, it is now pertinent to examine the experiences of the women once in general practice. It is evident that, in immediately or eventually practising single-handed, these women had rejected, for a variety of reasons, the accepted and more common way of practising medicine i.e. in groups and partnerships. The chapter uses the women GPs to illustrate how aspects of general practice are organised in relation to issues of gender by examining the early experiences in general practice which led them to single-handed practice. In the process, the attractions of single-handed general practice for the women are discussed.

7.1 The path to single-handed general practice

The contention of this chapter is that gender is a crucial factor in understanding doctors' orientations to general practice. Studies surveying the position of women in general practice were discussed in chapter 2 and these form the background against which the experience of single-handed women GPs are considered.

Single-handed women general practitioners are an example of a minority group choosing to operate in a particularly difficult and demanding area of professional practice. With growing government pressure to discourage

single-handed practice (see chapter 3) there is some justification for studying this small group of doctors. In particular, as will become evident, a study of single-handed women GPs highlights more clearly the problems and pressures faced by all women doctors and, on a wider scale, by all women in male-dominated professions.

The main thrust of this chapter is to examine the reasons why the single-handed women GPs decided to practise on their own. All the changes that have occurred in the organisation of primary health care provision (appointment systems, bleeps, deputising services, greater emphasis on partnerships, health centres, and so on) have been designed to ease the pressure on the GP and to increase efficiency in the delivery of services to patients. However, some GPs reject some (and in a few cases practically all) of the advantages and facilities of group practice in favour of working single-handedly. It will be argued that the reasons for this are structural, personal, and interpersonal and that there are specific reasons related to gender which encompass these.

Group practice came about as both a negative and a positive reaction to single-handed practice, as has been indicated. The recommendations of the Acheson Report (1981) were unfavourable to the concept of single-handed practice and favoured the use of incentives to encourage GPs to practise in partnerships and groups. However, many of those who now choose to practise single-handedly do so as a negative reaction against group practice and partnerships and because of a positive attraction towards single-handed practice. It is this negative/positive dichotomy that will now be explored empirically. It will become apparent that some of the important negative reactions against group and partnership practice are gender-specific.

These negative and positive reactions to group and single-handed practice are highly interrelated. They are discussed under four headings - financial grievances, personal relationships, continuity, and independence. A fifth dimension which interacts with the other four categories, gender and 'ghettoism', forms the concluding section in which the importance of gender influences throughout the chapter are brought into focus.

7.2 Financial Grievances

The financial grievances expressed by many of the women GPs were directly attributable to the structure of general practice (see chapter 3) and had contributed to their decisions to leave partnerships and groups for single-handed practice. Several respondents mentioned financial exploitation by male senior partners: this was particularly difficult to tackle because of the unequal status between the partners. Such grievances were closely related, also, to the problem of personal relationships which arises in many businesses (Goffee and Scase, 1985) and partnerships (this is discussed below). Financial problems were often linked with 'personality clashes , exacerbated by the unequal status which in many cases amounted to blatant exploitation, in that the women GPs felt they had to shoulder the greatest burden of work for the least reward. Some saw their male senior partners putting little effort into the practice, but reaping the greater financial benefits. Several women stressed how the 'financial hardship' (Pulse, 1983) which single-handed practice undoubtedly imposes was in most cases less onerous than their past experiences of financial exploitation by seniors in group practices.

Several different aspects of financial exploitation were raised. One woman, whose previous experience of practice had been solely with her husband, had steered clear of joining a partnership after his death even though, as she remarked, "Financially I would have been much better off" (no 1). Another experienced great difficulty in getting a single-handed practice, had been particularly keen to do so, and had not been disappointed when she achieved it because:

> Whatever you do you are doing for your choice, and whatever you get, you get it in your hand ....There (in a group practice) you worked and you didn't get anything in your hand ... you just did what the senior partner ... what he wanted, you did. (no 2)

Another GP described at length the financial aspects of her disillusionment with group practice, which she believed was crucially related to her two months' maternity leave. She explained 'a blow-up about money' as follows:

> Just before New Year's day they informed me that they didn't want me as a partner any more... I'd been a partner in a partnership of three with a list of eight and a half thousand. I'd been a partner for three years and should have got parity at the end of that ... The other thing I found out was one of the partners was paying himself £50 a month ... for doing the practice accounts. He never bothered telling anybody. (no 4)

The notion discussed in the Acheson Report (1981), that general practice is a business, found substantial agreement amongst respondents. For instance, one practice was:

> Just a standard general practice, run sort of as a business to make money, that was the attitude, you know. You look after the patients but it was to make money, it was looked on as a sort of livelihood rather than just done for the good of the patients. (no 20)

This leads to a consideration of 'altruism' in general practice. In arguing that general practice is a business there is the implication of a 'profit' motive at play, as suggested by doctor 20 above. However, as seen in chapter 6, none of the women mentioned the question of finance when giving their reasons for going into general practice - and few GPs would (in fact, only one - doctor 20 - discussed private' patients and financial imperatives). Did this 'business ethos' approach (see chapter 3) contribute to decisions to practise single-handedly? The evidence here suggests that it did since the women evidently preferred the control that single-handed practice gave them to manage their practices in their own terms and "for the good of the patients", rather than the profit/business motives of past practices where they were not in control. The inferences to be drawn from this in terms of gender are by no means absolute - but tentative correlations could be drawn here between women going single-handed and the rejection of male-dominated partnerships and groups. However, it is probably beyond the bounds of this project to argue the case of altruistic intent, as opposed to economic ones, in gender terms.

It was apparent that financial problems within general practice for the women GPs were related to their junior status at the time they practised in partnerships. However, there were aspects which were clearly gender related. For example, one woman talked about her many years of boredom as a doctor in public health[1] (an area in which many women work, to fit in with marriage and childcare, see chapter 6) and her excitement at getting

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1 The term 'community health' is now more commonly used.

out of public health and into general practice, which she had long wanted. Her initial experience was very disappointing: "it was pretty awful there. I knew I was being underpaid, but I wanted to get out of public health into general practice and that was the way I could do it ... but I continued to be underpaid". (no 23)

Evidence from the interviews, then, showed a considerable amount of financial exploitation within group practices. Respondents' junior status had led to their financial exploitation. The extent to which the deviant gender status of the women reinforced their junior status was uncertain. The interviews implied that the distance created by age/experience was multiplied by gender differences (as in the legal profession, see Podmore and Spencer, 1982a), but a comparative study of junior women and men GPs would be needed in order to confirm this. Obviously, such exploitation of one doctor by another does not occur in single-handed practice. But there were other factors which made single-handed practice appear attractive. The matter of personal relationships in group practice was frequently referred to by the women interviewed.

7.3 Personal relationships

Practising alone means never having practice quarrels or disagreements (Pulse, 1983). A number of the women interviewed referred to episodes involving disruptive personal relationships with their partners. Many of these experiences are mirrored in Goffee and Scase's (1985) study of women entrepreneurs. In their study, the women were not necessarily working alone but they were in charge of the business which they had started, and had chosen to do so largely in response to the experiences of their previous working arrangements.

Amongst the women GPs, while there was agreement that there are sometimes very positive facets to practising in partnership with others, many respondents were relieved, once they had gone into practice on their own, at not having to cope with their partners. The suggestion was made that group and partnership practice is in some senses the 'perfect set-up' - as long as you can cope with colleagues! As doctor no 4 said:

> The disadvantages are, for me at least, the people you work with, obviously. You have to, for it to work, you have to find colleagues who you can get on with.

She had found that in her experience there had been "a lot of animosity in the practice" where she had been previously.

The problem of unequal financial status within general practice discussed above impinged on the personal relationships between GPs. There was much discussion of partners putting different amounts of effort into their work, so that some respondents talked of the pressure engendered by lazy senior partners. One women expressed this in the following way:

> I mean I had this feeling that - which may have been slight paranoia, because we were so busy and I was very, very tired by then - it was like a paranoiac feeling that I was doing more work than anybody else. In fact I was just beginning to feel for the first time resentful that I was doing a man's job and doing everything at home as well. (no 6)

A successful partnership needs to be based on shared aims and values - it is more than just a financial arrangement. One woman felt that in the practice where she had worked, they all "got on well together, we were all

people who cared about people, and that was the principal thing". This comment was later qualified, however, as follows: "(They) reckoned to try and do a good job (but) one had to agree with the senior partner .... Provided you were sort of prepared to do what he wanted ... if I had stuck my neck out it wouldn't have worked"(no 8).

Practice relationships can go wrong between any partners, men and women, and one respondent (no 8) who had practised with another woman had relationship problems too: "It was very, very difficult and, increasingly, it became evident that ... we couldn't work together". The idea of a personality clash was given on several occasions as the main reason for changing practices: "eventually we decided that we'd have to split up". Another woman interviewed, who had only ever practised in a group practice as a locum for three months, put the idea succinctly when she said: "I mean having partners is very much like having a husband or a wife, you know, it s a lot of hassle ... You spend a lot of energy sort of coping with a partner, whereas you could be using that energy elsewhere" (no 18). And this view has been put forward by Barber:

> ... just as conflict and breakdown in marriage can result from the failure of husband and wife to come to terms with their differing personalities, so in a partnership there can be friction, unhappiness and breakdown. (1974: 112)

Five of the women interviewed had in fact practised in the past with their husbands. One had some particularly interesting things to say about that arrangement. She found that:

> More and more I was allowed to do more of the work ... He took a lot of time off, and because I was his partner, and couldn't really object because I was his wife, I ended up doing more work. And I suppose I got resentful. (no 21)

The literature on husband/wife partnerships in the profession tends to suggest that this is for the most part a supportive and positive way of working. In most of the professions it is not easy to draw a line between where professional and home life begin and end. In medicine, and very much so in general practice, professional and home life are closely interwoven (see chapters 9 and 10). For this reason a husband and wife working in the same profession - and, particularly, together - will offer understanding and be supportive of each other. However, this ignores the potential for exploitation inherent in such an arrangement and there were several stories of problems. As one women concluded: "It's not a good idea, husbands and wives working together, unless they ve got a very firm partnership agreement drawn up before they go into partnership"(no 21).[2]

There was little evidence that difficulties in personal relationships with partners were the result of differences in age or status or, at the first sight, of gender. However, problems <u>did</u> occur - how can these be understood? It seems that the desire to be free to organise and arrange their practice themselves became overwhelming for many respondents. Personal relationships (invariably with men colleagues, of course) began to deteriorate when the women began to question their destinies within their group practices. Along with financial exploitation, problems of personal

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2 See Chapter 10.

relationships may thus be seen as negative reactions against partnership practice. Continuity and independence, which are discussed next, act both as positive attractions to single-handed practice and as negative reactions against partnership practice.

7.4 Continuity

The notion of continuity refers to continuity of treatment from the point of view of both the patient and the doctor. The problem of lack of continuity for doctors involves not getting to know patients, or not being able to see through a course of treatment. For patients, the problem is of the difficulty of having to start anew with each visit to the surgery and thus never forming a relationship with any one doctor. In Cartwright and Anderson's (1981) study of general practice patients and doctors attitudes, issues of continuity in both partnerships and single-handed practices were compared. A high proportion of both patients and doctors believed that continuity was often lacking in partnerships but practically assured in single-handed practice. Both felt that continuity was highly desirable.

The women GPs interviewed were agreed that the problem of continuity was quite successfully overcome in single-handed practice. As one woman said: "It's a different quality of medicine I practise now than I did in the partnership". The question of quality and continuity is plainly apparent from her explanation of a group practice she had been in:

> the 8,000 patients that the practice had saw three partners and a trainee ... Although they were registered with certain people, obviously they didn't see that person, they saw whoever was available, or whoever they chose if they were lucky ... There was no continuity of care, really. (no 4)

Single-handed practice is often criticised because of the absence of possible consultation on cases between partners. There is, obviously, no possibility of referral of patients within the practice. However, the advantages of continuity for the doctor are considerable: "it's treating the unit as a whole that's enjoyable ... in the partnership I didn't get that sort of enjoyment" (no 4). Continuity can be viewed not only in terms of the treatment offered; the whole environment and doctor-patient relationship is affected: "In a lot of ways it's easier because I know everybody in this practice, and I know exactly what's going on ... they didn't come and see somebody else last week" (no 4). Continuity and relationships within the practice' can also be related to size of practice and list. From the doctor s point of view it is preferable for her to feel in touch with all her patients, which is not possible in a large practice with several thousand patients on its list. Comments from three women illustrate this:

> I think by having a small practice you can get sort of fairly chatty with patients. (no 6)
>
> I would really rather .... keep the practice small, so that we know everybody. (no 23)
>
> I think satisfactions are, making friends with the patients. (no 20)

It is apparent, then, that the comparatively small lists in single-handed practices allow GPs to know their patients and patients to know them, to build up a good relationship with patients (and vice versa), and to follow through a course of treatment from beginning to end, or until referral to hospital is necessary. These are all very positive functions of practising alone. One doctor spoke in terms of the satisfaction she had achieved

through the continuity of care in single-handed practice: "You have the satisfaction of following something all the way through and making a diagnosis before you send them off to hospital" (no 20). Continuity of treatment and care is important for both doctor and patient, but the question of independence is crucial from the doctor's point of view.

7.5 Independence

The notion of independence suggests two opposing themes. First of all, the desire for independence can be viewed in terms of doctors' positive entrepreneurial desire for their own practices. In this sense single-handed practice can be compared to the idea and attraction of owning and running a small business. Indeed the two have many common facets. Goffee and Scase's (1985) study of women entrepreneurs provides a useful comparison here. The data from the interviews with the women GPs pose a second and opposing theme, which comprises both negative and positive aspects. The negative reactions against partnership/group practice and the positive attractions to single-handed practice which are linked with the desire for independence concern the individual herself, rather than her immediate relationship to capital and entrepreneurship. It will become clear that this desire is also related to gender issues. As Goffee and Scase suggest:

> It seems reasonable to assume that although many women are similar to men in their expectations of the rewards to be derived from small business ownership, they will face distinctly gender-related problems. (1985: 8)

The desire for independence which the women GPs discussed was directly related to experiences of different aspects of exploitation in general

practice and is closely connected with the frequently expressed wish to practise in the way they wanted'. For example: "I decided that I'd like to run a practice in the way I thought it should be done," (no 6). And: "I've 9ot what I want ... from the point of view of the practice, a practice I started myself, and I organise and run in the way I like" (no 18).

The wish for independence was a negative reaction against past practice experiences and made single-handed practice appear attractive. A woman who had previously been in a large group practice with her husband demonstrated the dichotomy: "when the opportunity for this practice came up I accepted it mostly because I wanted to be independent and do things my way". She explained how working single-handed can make a difference in the organisation of a practice:

> It's a different system of working. I think if you work on your own, you can choose to do things as you want, like I have a special baby clinic, I have a special ante-natal clinic, all coming separately for different clinics ... Being independent you can organise you own timings and you can run things exactly as you want it. (no 19)

The notion of independence and being able to 'run things exactly as you want it' in single-handed practice facilitated the resolution of what had been problems in past practice experience:

> There used to be a gynae session with the other practice where all the women with gynae problems were seen on a Friday morning. Now I do it all, but it's the attitude that is different because you're not sort of coming in on a Friday morning thinking "God ... I've got thirty women!" The quality, I'm sure, it must be better at the end of the day ... it feels easier anyway. (no 4)

Here is a clear example of the woman's gender status leading to her being allocated a certain ('low grade') category of work within the group practice, and her junior status making it impossible for her to resist such an imposition. For such women, single-handed practice represented - for all its problems - a 'way out'.

Independence and freedom in organisation were all expressed in terms of 'being the boss' which was described as an important element of satisfaction: "It's a great satisfaction being my own boss. I mean I can do exactly what I want to do; I like that, I like that aspect of it" (no 20).

Independence and the individual's positive/negative attraction to single-handed practice have so far been described in terms such as being 'freer' and being able to do my own thing'. Control, though, was another term used in explaining independence:

> I wanted to have control over the rest of my working life, which I in a large practice was not going to have. The person who was senior to me in the practice was younger than me in years, so no way was he likely to retire before me, and I just felt that I wanted to have control over what happened. (no 23)

'Wanting to control' is important. It can be related to the norms of professional training which stress not only independence but embody also the concept of superior knowledge gained in the process of training which is both highly specialized and of considerable length. The model of the traditional GP portrayed in chapter 1 embodies such ideas. Here the GP worked independently and, through maintaining such independence and along with his professional training, was assured of a degree of deference from patients based on a supposed superior knowledge. Partnership

practice necessitates relinquishing some of the ideas of independence inherent in the medical socialization process, in favour of norms of both co-operation and hierarchy between partners. These can also affect (possibly for the better?) the deferential nature of the patient-doctor relationship which is so apparent in the traditional single-handed practice. Changed ways of practising are anathema to the traditional concept of the professional, while single-handed practice is its tangible expression. The desire for control expressed by the single-handed women GPs can be understood in relation to such a background, in its being the best way they can express their professional socialization. When feelings of lack of autonomy and impotence were mentioned, these were very much in opposition to the professional norms which they had internalized. For example:

> when I was there I realized I was treated more like an employee ... None of my ideas or nothing was needed there, I was just pushed around and felt I was doing all the work there, so I thought I'll move out and have my own practice. (no 5)

So a desire for independence and control over their working lives was in many cases a result of and a direct response to negative past experiences in partnerships, as well as of a positive attraction to the independence and individualism instilled by professional training which is satisfied by practising single-handedly. This positive/negative dichotomy in the explanation of the desire for independence is in opposition to the entrepreneurial thesis, which discusses independence and control in terms of capital and which has been explained elsewhere in terms of a desire 'to paddle their own canoes' (Pulse, 1983).

7.6 The Fifth Dimension - gender and ghettoism

The reasons for practising single-handedly, discussed in terms of financial grievances, personal relationships, continuity, and independence have shown that there are positive attractions to single-handed practice and negative reactions against partnership. In the discussion so far the Issue of gender has been considered only peripherally. However, gender is an important aspect of the decision taken by women to go into single-handed practice. This 'fifth dimension' of gender can be looked at from two perspectives. First, gender is a central consideration in interpreting the four areas already discussed. It can be demonstrated how explicit examples of the exploitation of women doctors have an overall part to play in the 'discriminatory environment of general practice (Bourne and Wikler, 1978) which shapes the decisions and actions of women GPs. Second, there is the issue of what can be termed 'ghettoism', which is a feature of the discriminatory environment. This means that women are 'ghettoized' within group practice into certain areas of general practice in much the same way as they are channelled within medicine generally (see chapters 2 and 6).

Cartwright and Anderson have noted that: "In general it is the lack of difference between men and women general practitioners which is most notable" (1981: 127-28). While the present study is not of a comparative nature, the women GPs interviewed suggested many instances where gender was a definite factor in their experiences. This was discussed as a general issue as well as more specifically and personally:

> If I had gone into partnership, financially I would have been much better off, but I thought about all these upsets ... and especially for the lady doctors, I hear that men doctors, they exploit a lot, so I was not prepared for it. (no 1)

A GP, in talking of her difficult practice experiences - which she attributed to being a woman - suggested that it was not a personal problem but one of gender generally: "they ve taken on a lot of lady doctors since and bullied them terribly" (no 27).

Through a consideration of the notion of 'ghettoism' it becomes apparent that gender-associated problems pervade each of the four categories discussed above. While women are channelled into certain areas of medicine generally, they are channelled within general practice too. Ghettoism occurs when women doctors find themselves seeing specific categories of patients in a group practice - many of the women, especially for specifically women's problems' (gynaecological, obstetrics, and family planning), many of the psychiatric cases (a large proportion of whom are women) (Young, 1981), and the paediatric cases, especially when children are brought along to the surgery by mothers.

There were a number of examples of this sort of ghettoism:

> (In) the practice that we joined, there were four men so ... I was doing mainly gynae and maternity and paediatrics and seeing children. (no 27)

> we had got the midwife to give a little bit of help in ante-natal but I was doing the whole lot, all day I was doing it. (no 11)

The notion of ghettoism implies not only that women doctors see particular categories of patient, but that this is **imposed** on them to a large extent. In discussing reasons for becoming GPs, it was clear that many women chose positively to follow a career in general practice. They had for the most part become general practitioners in preference to specializing in hospital medicine (although Turner (1979) has suggested that general practice is often a second choice to hospital medicine - the case for some of the GPs in this study). The specific choice though, for the majority of respondents, had been not to specialize. General practice implies offering the full range of medical care; that is one of its principal attractions. So while interests and specialisms within general practice may naturally arise, doctors do not expect these to be imposed but followed through choice. In the case of the ghettoized women GPs in this study, choice was not a factor in their past experience whilst they were working in group practices.

The imposition of ghettoism came from several sources as has been shown above; first, in respect of assumptions which were made about the sort of medicine they should, and would like, to practise. These assumptions were made by male colleagues and seniors, by some female colleagues, by themselves, by other practice personnel (e.g. receptionists, nurses, midwives, etc.) and by patients. Assumptions were made that because they were women doctors, they should want to treat women and, particularly, women's problems . The normative expectation was that women doctors should treat women patients. This arose out of their supposed common experience as women and the supposed innate 'feminine' characteristics of women doctors (discussed in chapter 2) which include being more 'sympathetic' . These views are shared both by health professionals (male and female doctors and other practice personnel) and by patients.

The supposedly sympathetic nature of women doctors can lead to patients exploiting this view: "I think the patients talk too much to women. I often find that they'll sit here and they'll talk to me over things I know jolly well they wouldn't feel free just to bring up what they want to a gentleman" (no 20). This situation was seen as having both positive and negative aspects:

> To some extent it's nice, because it means that the patients will talk to'you more freely and tell you problems earlier; on the other hand it s a nuisance when people just sit there chatting to you.
>
> a lot of patients think they can take advantage of women a little easier than men. (no 20)

Respondents suggested that because many patients, particularly women, viewed them as more 'sympathetic' they were very popular, and consequently busier than male partners and this was 'because I was a woman'. In essence, however, it was because women GPs saw the bulk of the women patients and children that they were so busy. Many women patients prefer to see a woman doctor for gynaecological, obstetric, and family planning consultations not only because of their common experience and their supposed sympathetic nature, but also to avoid facing possibly embarrassing situations with male doctors (this can happen in reverse for men patients, though very much less frequently). The fact that women patients prefer to see a woman doctor came out clearly in the interviews: "I found a lot of women came to see me. I did find I had a lot of woman problems'" (no 11).

It is evident, then, that a form of specialization within general practice is imposed on women GPs. While it must be recognized that many women

doctors are happy to treat a large number of women patients, they have for the most part not chosen to specialize in obstetrics and gynaecology, etc.,[3] but, to all intents and purposes, find themselves doing so. This ambiguous situation must be put into context through comparison with hospital medicine. In order to specialize in obstetrics and gynaecology it would be necessary to follow a hospital career. However, these specialisms in hospital medicine are male-dominated ones, being top-heavy, at the consultant grades especially, with male doctors. Women have difficulty in progressing far, in much the same fashion as occurs in many other surgical specialties. Personal experience, along with many other alleged 'feminine/innate' characteristics such as being sympathetic and dextrous, for example, are not seen as valuable or helpful to a career in obstetrics and gynaecology specialisms in hospital medicine (as seen in chapter 6, 6 women had attempted to specialize in obstetrics and gynaecology in hospitals but changed to general practice). In general practice, though, the situation is the complete reverse, and for many women GPs it is not a position of their own making or choice. The women interviewed in this study found that single-handed practice went a long way towards allowing them to practise the sort of medicine they chose. It allowed them more choice in the sorts of patients and conditions they were exposed to, so that they were able to experience a much fuller range of medical care, rather than specializing. Inevitably, these women GPs still spent a proportion of their time treating 'women's conditions' and for the most part were happy to do so, but they were also now exposed to a much wider' range of patients and conditions and were consequently more completely general practitioners.

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3 See chapter 12 for an explanation of the Asian women doctors' attraction to this specialism.

Being a woman GP in a group/partnership practice affects the practice in its operation. It affects, too, the woman GP herself in terms of her financial relationship to the practice, her personal relationships with other members of the practice, how the continuity of treatment affects both doctor and patient and the independence and control which doctors have within the practice. It is recognised that the junior status of most of the respondents at the time they worked in group practices also contributed to their particular experiences. The precise influences of gender and of status in a partnership can be understood only by further research, constructed on slightly different lines to this project. However, it is argued that enough has been shown in this chapter to demonstrate the importance of a 'gender effect' on women's experiences in group practice, even if its precise weight cannot be measured. Being a woman GP in a group partnership/practice also exaggerates the effect of ghettoizing doctors into certain specialties; for women this occurs in the treatment of 'women's' and children's conditions. The **gender** of the doctor (the fifth dimension) is not only a reactive force on its own, but interacts with the other four categories in contributing to decisions made to practise single-handedly. Many reasons were given for practising single-handedly, but for the single-handed women GPs in this study, decisions taken to practise alone were directly related to gender issues, though the women themselves did not always articulate their reasons in this way. In discussing gender issues in relation to choice of practice it must be recognized that career choices are not made in isolation (as was seen to be the case in chapter 6). For women GPs, gender issues must also include the discussion of how they organize their out-of-hours cover (see chapter 9) and their domestic situations (chapter 10) and how these different but connected areas of life are reconciled. These, too, are of relevance to practice strategies and decisions.

It has been argued in this chapter that the data which suggest a trend in general practice towards doctors practising together in partnerships and groups are gender blind. In fact this trend has moved much more slowly for women doctors than for men in general practice in Birmingham, since the proportion of women to men practising single-handedly is considerably greater than the proportion of women to men in general practice overall. It is apparent that the reasons for this are closely related to gender issues. Negative experiences of group practice have attracted women to practising single-handedly, experiences which have interacted with gender issues and the power relationship between men and women. These negative experiences are epitomized in the concept of ghettoism, a term used to describe the way in which women GPs are channelled into a limited form of general practice to which, traditional stereotypes suggest, they are particularly suited. Where their roles are circumscribed in this way - usually by their male superiors and colleagues, but sometimes by their patients and themselves - women GPs may well respond by continuing to opt for single-handed general practice.

In chapters 8 and 9 aspects of the practices of the single-handed women GPs are examined more closely: in chapter 8 their premises, resources and facilities and relationships with ancillary workers, and in chapter 9 the arrangements made for out-of-hours cover.

CHAPTER EIGHT

GENERAL PRACTICE PREMISES AND THE PRIMARY HEALTH CARE TEAM

The path leading to general practice and subsequently to single-handed practice has been shown to be strewn with obstacles. The experiences which the women GPs described have led them in various ways (and through differing circumstances), to the same situation - that of single-handed general practice. In chapter 7 the experiences of group and partnership practices were analysed and compared with the expectations and the reality of single-handed practice. Along the various routes taken to single-handed practice, a variety of factors channelled the women along the way. It was argued that the issue of gender was of fundamental importance in influencing and shaping these women's lives, whether explicitly or indirectly, whether acting alone or interacting with other factors.

This chapter explores more closely the single-handed practices of the women interviewed. It looks at both structural and interpersonal aspects of the practices: practice premises, resources and facilities; and use of and interaction with members of the primary health care team.[1] It is hoped to

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1 The Primary Health Care Team, as defined in the Harding Report (1981:2) is:

> .... an interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service.

illustrate the special nature of single-handed general practice and, though the issue of gender is not highlighted in the discussion, some gender related inferences are drawn.

8.1 Premises, resources and facilities

In chapter 3, aspects of general practice were examined, with a special emphasis on those aspects which were relevant to single-handed practice. In looking at practice premises, it was noted that those of many single-handed GPs had been heavily criticised by the Acheson Report (1981) for poor quality, unsuitability, lack of essential facilities, outdated premises and facilities - particularly in inner cities where surgeries tended to be of the lock-up shop variety. Some of these elements were apparent among the women GPs, but conversely there were good quality premises, some attached to doctors' homes, others in health centres and clinics. Overall, the quality of premises and facilities covered a wide spectrum from very good through to extremely poor and totally inadequate. Acheson's criticisms of the lock-up shop variety of surgery were for the most part supported, but not totally - this type of premises did not preclude some degree of quality.

Premises and available facilities were not subjected to detailed inspection (or measured against any scale of quality), since it was felt that this could have put some of the doctors on the defensive, and might have made them less cooperative. However, notes were made of impressions gained of the practices and these were written up after the interviews.

Eleven of the 29 doctors' surgeries were attached to their homes. In the 'ideal type' of traditional 'family doctor' discussed in chapter 1, this was one of the important characteristics of general practice. The eleven attached surgeries were divided between (1) those that were purpose-built extensions to the home (3 cases), (2) those that had entailed extensive internal alterations to the home (4 cases), and (3) those which were no more than a room in the home, which had entailed no adaptation (4 cases). This can be seen in Table 8.1.

Table 8.1 **Eleven sugeries attached to GPs' homes**
(Doctors shown in brackets)

Purpose built extension to home	3 (1, 3 (not seen), 19)
Extensive internal alterations	4 (9, 10, 18, 23)
Not adapted	4 (16, 17, 26, 29)

Quality of the surgeries[2] in the first two categories was generally high, but less good in the third category. None of these surgeries, however, were of the poor quality of some of those which will be described later in this section. The best surgeries had some (but not all) of the following features: separate entrance from the house; large and spacious surgery; central heating; carpeted and good/clean decorations; comfortable waiting area; adequate area for undressing; internal toilet with wash-hand basin; separate room for use by ancillary/health authority/nursing personnel, or

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2 As stated above, 'quality' was determined by means of purely subjective assessment.

for dressings/examinations etc;[3] reception area separate from waiting area; and adequate car parking.[4]

The Acheson Report recommended that each main surgery, to qualify for rent and rate reimbursement should possess:

> a separate consulting room, waiting room, a wash-hand basin and a flush lavatory. There should be an examination couch either in a separate room or in the consulting room capable of being screened from the rest of the room. Decor and fittings should be maintained to an acceptable standard. Wherever possible accommodation for other primary health care workers should also be included. (1981:43)

The practices attached to GPs' homes, therefore, were well above the minimum standards recommended in the Acheson Report, except that they lacked accommodation for other primary health care workers. The fact that the surgeries were attached to the home of the GP is indicative of the quality of the premises. Not surprisingly GPs tend **not** to live in "unattractive areas" (Acheson Report, 1981) even if they practise in them. This was the case for the women GPs in this study, so that all eleven who practised from surgeries attached to their homes were in desirable areas and (another point worth noting) were serving a mainly middle-class patient community.

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3 Only three surgeries of the 26 viewed had such a room - one of which doubled as the bathroom.

4 No practices attached to doctors' homes provided off-street parking for more than three cars, including the doctor's car, and most provided none.

The remaining 18 doctors' surgeries[5] were not attached to their homes, and there were very mixed standards amongst them. These surgeries can also be divided into three groups and are shown in Table 8.2. The first group (6 cases) consisted of those occupying a surgery in a health centre or clinic (rented from the health authority) or shared practice premises. The second group (7 cases) were those who had converted or used purely for surgery purposes a house in a residential area. The third group of surgeries (2 cases), were of the lock-up shop variety, and it was surgeries in this group (and two in the second) which manifestly failed to meet the recommendations on minimum standards suggested in the Acheson Report. Some features of the lowest quality premises included: no toilet, or an external one, dirty and without a wash-hand basin;[6] very poor decorations (as in one surgery where paper and paint were peeling from the walls and there were numerous damp patches); inadequate floor covering (e.g. no carpet, broken linoleum, or bare floorboards); inadequate heating (such as a one bar, free-standing electric heater on a very cold winter's day); uncomfortable, cold, stark or cramped conditions in the waiting area (some used a corridor, or did not have enough chairs, and lacked recent magazines or other reading material or toys for children to play with whilst waiting);

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5 Three practices could not be viewed since the interviews with the doctors took place in their homes.

6 The toilet was one common feature at all surgeries it was possible to inspect without alerting suspicion - except that on two occasions I was advised not to use the patients' toilet as it was "not very nice". The surgeries of the very lowest quality had the worst toilet facilities for patients' use. One had no toilet (there is no requirement to provide one if there are public toilets close by the surgery), and several were outside (one without a ceiling and open to the sky - and rain!), and cold, dirty and without a wash-hand basin. Another feature of some was that they were upstairs and therefore out-of-reach of some patients.

evidence of vandalism such as broken windows and a boarded-up front door. One lock-up shop surgery had no electricity to the building! These features were ones that were plainly evident, without close or detailed inspection. These very worst surgeries (4 out of the 26 visited) thus presented a most depressing aspect of health care in the 1980s.

Table 8.2 **Surgeries not attached to GPs' homes**
(Doctors shown in brackets)

Surgery in health centre or shared practice premises	6 (4, 7, 11, 20, 24, 28)
Converted house - sole use as surgery	7 (2, 5, 8, 13, 14, 21, 22)
Lock-up shop	2 (15, 27)

Two GPs, one of whom had very poor quality premises, were so well aware of the embarrassing state of their premises that they apologised for their condition. Three others were in fact in temporary premises, and others were either attempting to find new premises, waiting for planning permission for alterations, or waiting for alterations to new surgeries to be completed. However, the doctors with the very worst surgeries and premises were not amongst those who said they intended moving or upgrading them.

The doctors with surgeries in health authority premises (6 cases) such as health centres or clinics, or who practised single-handed from the same building as a group of doctors, all had good quality premises. They did not include any of the worst features of poor quality surgeries listed above. Although surgeries were sometimes small, waiting areas and examination areas were well provided for, and surgeries were well furnished, light, and

centrally heated. All the premises included good toilet facilities for patients. Two doctors had recently moved into the health centres from much poorer quality premises. They felt satisfied with the move, stressed some loss of control over their practices but felt there were compensations in terms of the better quality premises. Another feature of being in good quality premises was that there were better possibilities for facilities for ancillaries and other members of the primary health care team. Doctors were able to share those facilities at much less cost than providing them totally alone. In addition, of course, purpose-built health centres are well provided with off-street parking facilities - a factor which was rarely possible with other types of premises.

An important consideration when assessing quality of premises is one which is often overlooked. Patients who register with a single-handed GP do so for a number of reasons, such as continuity of treatment (see chapter 7), getting to know the doctor and so on, and they are also often attracted by the image of the traditional 'ideal type' GP described in chapter 1. While being women meant that respondents were deviant from the traditional 'ideal type', there are many other aspects of their practising single-handed which have made them comparable with the 'ideal type' GP - and it is likely that they are viewed as such by many of their patients. One particular feature of such GPs was that their practice premises were so often (11 out of 29 cases) attached to their homes. This made them appear 'homely' rather than 'clinical'. While it was not possible to determine the extent of this sort of attraction as far as women GPs in this study were concerned, it is probable that being 'homely' was a popular feature with patients attracted to the traditional single-handed practice. It is certainly true, in the interviewer's assessment, that the health centre surgeries (despite

other advantages) were more 'clinical' than those attached to the GPs' homes. Health centres, in that they depart from the traditional image of the GP, are less likely to find favour with patients who are attracted to the 'family doctor' concept of general practice. Some GPs, too, are aware of that which is lost by health centre practice. Cartwright and Anderson (1981:75) found that 24 per cent of all GPs perceived one of the disadvantages of working in a health centre to be 'loss of homely atmosphere'. Jefferys and Sachs (1983:305) assessed the opinions of patients on their doctors moving to a health centre from a variety of different premises. They found that the sizeable minority who preferred the previous surgery premises usually referred to its 'friendlier, less formal atmosphere'. These replies, however, were from patients of doctors in group practices with three or more GPs. So, no direct comparisons can be drawn from the Jefferys and Sachs work to support the contentions of this study. It seems highly likely, however, that a 'homely atmosphere' is one of the attractions of a practice for those patients who have sought out, or purposely stayed with, a single-handed GP whose practice is situated in a house.

The surgery premises of the single-handed women GPs thus ranged over a wide spectrum of quality. One particular way, however, in which the vast majority of these premises (23 of the 26 surgeries seen) did not come up to the standards recommended in the Acheson Report (1981) was in terms of the provision of accommodation for other primary health care workers. This inevitably affected the use of, and relationship with, these workers. This matter is examined in the next section.

8.2 The primary health care team in single-handed practice

While for the most part the women GPs did not provide accommodation specifically for the use of other primary health care workers (only three such practices were seen) this does not mean that such workers were not used to provide a primary health care service for patients. The use of receptionists and/or secretaries, health visitors, district nurses and midwives, all members of the primary health care team, will be discussed in terms of their contribution to the practices in this study, as viewed by the women GPs. The relationships with and attitudes of the GPs towards the members of the primary health care team will also be considered.

There was considerable resistance amongst the women GPs to the idea of the primary health care team. This is not surprising, since amongst the reasons for these doctors being single-handed was the poor experiences and relationships they had experienced in working with others in group and partnership practices (see chapter 7). In addition, amongst the attractions of single-handed practice had been the image of the traditional 'ideal type' GP which such practices embody. The difficulty of providing accommodation for primary health care team members by the single-handed GPs has been indicated too (see chapter 3), but it is obvious that the **will** to do so was also lacking.

The women GPs did have some assistance in their practices, of course. All used receptionists/secretaries, mostly on a part-time basis. Many had two or even three receptionists employed on a sessional basis through the week. The need for this type of assistance is evident and such use is to be expected, particularly amongst those GPs who viewed themselves in the

traditional image - traditional **male** GPs typically made use of their wives in this role.[7]

While receptionists were clearly an essential part of the practices, other members of the primary health care team were less in evidence. All but six[8] of the 29 GPs mentioned making use of health authority staff - district nurses, health visitors, midwives and a few social workers. None, though, were directly employed by the GPs. There was general agreement amongst the doctors who made use of these staff that there was a role for them in general practice. However comments such as "they tie you down (to particular times and sessions)" (no 21) were typical of GPs who clung to the traditional 'family doctor' concept. Such GPs rejected more recent organizational changes in general practice such as appointment systems, or specific clinic sessions (e.g. antenatal clinics, baby clinics, and so on). One woman GP justified making very little use of health authority-employed personnel within her practice and not running specific clinics because of the way it made her view her practice and patients:

> I haven't really come to any conclusions about these clinics .... (but) to me if its all immunisations or it's all antenatals you begin to think of people as antenatals or immunisations .... (no 18)

It is obvious that the more people who are involved in the work of a practice the more important 'organizational' factors become. The running

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7 Only one doctor in this study (no 16) had her **husband** fill this role to some extent - see chapter 10.

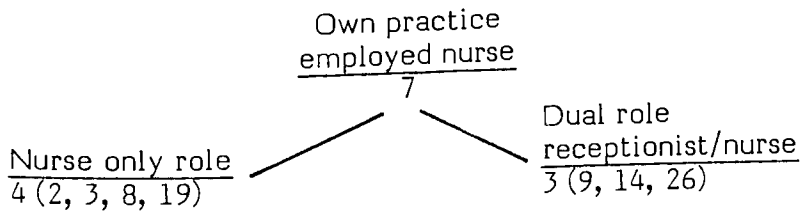
8 This did not necessarily mean they did not use them.

of specific clinics, involving other personnel, was a factor that made some of the GPs express feelings that their control over their practices would to some extent be threatened by their use. One of the major reasons why they chose to practise single-handedly was to get away from 'organizing' and 'bureaucratizing'. In fact, delegating patient-related tasks to midwives and health visitors, etc. presented doctors with a dilemma. The doctors accepted that such workers were valuable for community use, but saw them as less acceptable for use within the practice itself.

The use of nurses within practices was viewed differently however. Seven doctors had their own practice-employed nurses (part- and full-time), and they were used in a number of ways which are shown in Table 8.3. Three of them had nurses with dual roles who acted as receptionist/nurses, which was found to be helpful. It is useful for receptionists to have some sort of medical training when dealing with patients' problems both face-to-face and over the telephone. Nurses were used in a variety of ways in patient care. For instance:

> We never had a nurse in the previous ... arrangements, so it's taken the patients a little while to get used to it, but increasingly they are consulting the nurse, the nurse is doing repeat prescriptions ... well obviously I sign them and check them ... (no 8)

Table 8.3 **Use of practice nurses**
(Doctors shown in brackets)



Doctor 14 had a nurse/receptionist:

> She is here all the time, and she can deal with the minor injuries and minor things like ... ear syringing ... and so on, and judge literally which patients need a home visit and which don't and which ones she's got to rush in immediately to hospital if I'm not here. I couldn't run it without her ... And in fact she's very very good because she also types, so she can do my letters too. (no 14)

Other doctors legitimised not employing nursing staff because of cost (despite being able to claim back 70 per cent of their salaries from the Family Practitioner Comittee). Doctor 28 for instance:

> I did have a nurse, but really it cost me too much. (no 28)

The Acheson Report saw the advantage of the practice nurse from the GP's point of view as:

> in addition to enabling **him** to make best use of **his** own skills, she can also perform tasks under **his** supervision which health authorities are unwilling to authorise their nurses to perform (1981:58)[9]

The role that practice nurses perform in general practice was criticised in the Acheson Report too, as well as elsewhere (Harding, 1981; Cumberlege, 1986). Criticisms have been made not only of the lack of developmental training for such nurses, but in the divisiveness their presence has in terms of developing the role of the primary health care team. This is because

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9 The emphasis has been added to demonstrate the assumptions made in the Acheson Report that GPs are male.

district nurses are then used solely in the community and do not gain the experience of treatment room work which enables them to develop both a community and general practice linked relationship with patients, thus more closely integrating these different aspects of patient care.[10]

There was little discussion by the GPs of relationships with community nursing staff. In fact, except for doctors who had their own practice nurses, there was a general defensiveness and unwillingness to discuss this aspect of practice life. This may have been, as suggested earlier, related to problems of delegating tasks where this seemed to mean the relinquishing of some control within the practice. They preferred to safeguard their independence in working alone as much as possible.

This section has looked briefly at the relationship of the single-handed women GPs to other members of the primary health care team. It can tentatively be suggested that use of such staff was minimized or avoided in their practices for five reasons which are interdependent. First, the extensive use of such staff within the practice was seen as potentially affecting the role of the GP within her own practice, in a way which could inhibit her authority and control in both organizational terms and vis-à-vis her patients. Second the accommodation of primary health care team members within the practice necessitates the replanning of the practice in both spatial and organizational terms. Third, the reluctance of many of these doctors to wholeheartedly incorporate community nursing staff

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10 These studies consider these factors in more detail than is relevant here, and in addition make recommendations on the use of health authority personnel in general practice.

within the surgery team implies a fear of loss of the independence that becoming single-handed GPs has given them. Fourth, there is also the implication that the women GPs were acting defensively about the idea of change within their practices, in that they were internalizing such an idea as self criticism. Fifth, the reluctance to incorporate community nursing staff within the surgery seemed to be particularly strong amongst those GPs who viewed themselves as traditional 'family doctor' GPs e.g. by not using appointment systems or organising particular clinic sessions.

Relationships within the practices of the women GPs were evidently not viewed by them as an issue - as employers the GPs did not see themselves as a problem, nor did they incorporate community nursing staff within the practice where they may have been seen as a potential problem or threat. Hence, the image of very harmonious working relationships within the single-handed practices was engendered - in a sense, the complete opposite of relationships in groups and partnerships which many women had experienced earlier.

The examination of practice premises in this chapter has confirmed some of the findings of the Acheson Report (1981) and Bolden (1981) on the poor quality of inner city single-handed general practice premises. However, it has also shown that single-handed practice premises are by no means all run-down and neglected, especially where they are attached to doctors' homes or in health centres. Nevertheless, most of the practices confirmed the Acheson Report findings of a lack of accommodation in single-handed practices for other members of the primary health care team, such as community nursing staff (midwives, health visitors, district nurses etc). Where GPs were updating or moving premises however, there were a few

examples of attempts to make such arrangements possible - but they were few (two cases).

Such a situation inhibits the possibilities of use of community staff to any great extent, and few attempts were made to use them within the surgery. However, they were seen as useful for working within the community itself. The lack of suitable accommodation for such staff could be interpreted as strategic and defensive behaviour on the part of the women GPs in seeking to retain control over their practices. The preference for employing their own practice nurses (seven cases) could also be viewed as an attempt to retain control within their practices. The incorporation of health authority employed staff (i.e. people not employed directly by themselves) could be seen as possibly threatening such control.

It is evident that such arguments are related to factors concerning single-handed practice, and are not gender related as such. But, the poor relationships which many of them had endured in past groups and partnerships as **women** GPs, may have some implications for their defensiveness against potentially allowing such problems to develop within their own practices. Gender related inferences on practice premises and provision for and use of members of the primary health care team can be drawn in this way.

Discussion of the various aspects of single-handed general practice cannot be considered in isolation, and they lead on to the consideration of the women GPs' lives outside of their practices, i.e. the domestic sphere of their lives. There is, though, a linking or bridging between their practice and domestic lives in terms of out-of-hours cover and the issue of being on-call for their patients. These issues are examined in the next two chapters and confirmed as gender issues.

CHAPTER NINE

OUT-OF-HOURS COVER: A GENDER ISSUE

This chapter on out-of-hours cover discusses several important issues. It takes the women GPs' professional and domestic lives and, rather than viewing them as two separate entities of life, it examines the link or interface between them, where the one intrudes into the other.[1] For GPs this intrusion is particularly manifest in the shape of the on-call periods for out-of-hours cover. Out-of-hours cover mainly concerns availability for home visits and the offering of advice to patients outside of normal times. Home visiting could appropriately be renamed 'out-of-surgery' calls, since this includes calls taken and made night and day, emergency and routine, patient and doctor-initiated. However, the important issue is how this 'link area' or interface between the professional and domestic aspects of life affects both, how it acts as a bridge, and how both aspects of life intrude one into the other in a two-way continuum. This is the aspect of the GP's life where professional work can be seen to be 'invading' the domestic situation and where separation of the two aspects of the GP's life is least defined (Finch, 1983; Sharpe, 1984).

The question of deputising services and out-of-hours cover has been briefly considered in Chapter 3. As indicated in that chapter, no attempt has been made to observe the effect of doctors' gender on out-of-hours cover and

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1 See Finch (1983) for examples of other professions (e.g. the clergy) where the influence of work on the home and family, and vice versa, is discussed.

deputising service usage. The following section will use the data collected from the interviews with the single-handed women GPs to examine this. It will become evident how many of the problems experienced in covering out-of-hours calls and home visiting which are related to gender are exacerbated in the case of GPs who practise alone. Examining the experiences and strategies of single-handed women GPs in organising this aspect of their lives will serve to clarify the gender issues.

9.1 The organisation of out-of-hours cover - past practice experience

The majority of the GPs (19 of the 29) used the deputising services to some extent for their out-of-hours cover. Of the 19 GPs, seven used the deputising services for all out-of-hours cover, 11 used them irregularly, although the variations within that category were wide, and one used the service on very rare occasions. The other 10 GPs, who made no use of the deputising services, had other arrangements for dealing with out-of-hours cases. Two GPs had rotas but these were GPs who, as it turned out, were not strictly single-handed.[2] Three were in some sort of rota system with neighbouring practices for some of their out-of-hours cover, although they did most of their own calls themselves. Three others took all their own calls. There was some use of answering services to take and hold messages for GPs, but this was small. Table 9.1 summarises arrangements for out-of-hours cover.

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2 Both were registered as single-handed GPs with the respective Family Practitioner Committees and are therefore included in any data given out on single-handed GPs - they are therefore included in the study. One worked in a university health centre practice (no 7), and the other was a salaried partner in a practice, but part-time with no nights and weekends on-call herself.

Table 9.1 **Arrangements for out-of-hours cover**

Arrangement		No	Doctors
Always on call		3(+1)	4,26,28 (+ 16*)
Uses deputising service	Rarely	1	6
	Sometimes	11	2,5,8,10,17,18 19,20,21,22,24
	Always	8	9,11,12,13,14,15, 16*,27
Rotas	Sometimes	3	1,3,23
	Always	2	7,25

* Doctor 16 had used the deputising service for 3 years after previous 30 years of always on-call.
Arrangements for doctor 29 were not given.

For many of the GPs the arrangements for out-of-hours cover were not necessarily made out of choice. Some arrangements were due to circumstances and availability of support services, others were due to past practice experiences which had made them resolve to organise out-of-hours cover differently from previous practices in which they had worked (see chapter 7).

In group and partnership practice one important way in which support is manifested is where out-of-hours cover and 'on-call' periods are concerned. While a considerable amount of use is made of the deputising services in groups and partnerships, there is little difficulty in arranging rotas between partners for this purpose. Rotas are used more widely in larger practices and the more partners in a practice the easier this is to organise and in this situation the less a doctor has to be 'on-call'. Therefore, rotas arranged between practice partners, along with the use of

the deputising services in some practices, mean varying amounts of 'on-call' involvement depending on size of practice and the support services. In a hypothetical practice with five partners, for example, which covered all its 'on-call' periods by rotas divided equally between the five partners, with no use made of deputising services, each doctor would be on call one night a week and one weekend in five. On the surface such an arrangement might sound ideal; it is certainly easily manageable in terms of disruption to personal life. However, a five-person practice could have as many as, say, 15,000 patients on its lists (if each doctor had a list of 3,000 patients) and this raises other issues in terms of out-of-hours cover. For example, one GP interviewed described just such a situation and explained it as an overwhelming experience. As she said of her time in a large practice:

> you were covering about 14,000 patients when you were on-call .... it used to be the millstone that I was frightened would be with me all the time .... it's quite different if you're on-call for 14,000 ... (no 4)

If, as this GP suggests, the responsibility and pressure of being on-call (albeit infrequently) for so many patients at one time is so stressful, then perhaps it should be organised differently. It could, for instance, be possible to arrange to have two partners available at a time to ease the stress of being on-call, but with more frequent turns on the rota. Alternatively rotas can, and often are, combined with use of the deputising services, to either take and make calls or just handle messages. There are a number of different arrangements which can be made to handle the pressure of being on-call for very large numbers of patients. However, these pressures are not always recognised and may lead to GPs using other strategies to counter them. Strategies that can be used are to opt out of

such a practice by choosing a practice with different out-of-hours arrangements; or by taking a single-handed practice. This could be viewed as running away from the problems and pressures of group practices since it does not entail any attempt at coping with the problems which exist in such practices (see the discussion in chapter 7). Nor does it remove the question of how to organise out-of-hours cover in a new practice. In discussing rotas in group/partnership practices it must be remembered that few five-person practices are organised as the one given as a hypothetical example. Practices very often are not organised in terms of equality but in a hierarchical fashion so that more junior members of the practice are likely to take on more of the out-of-hours, on-call responsibility. This had certainly been the case for a good proportion of the GPs in this study, since for many of them their experience in groups was at a junior level. Many (9) of the women interviewed had not practised as principals or full profit sharing partners in the past in group practices, but as assistants or salaried partners without full parity. Others had worked in general practice for several years before gaining full parity. This meant that they had little power over the organisation of out-of-hours cover.[3] This cover is inevitably seen by senior partners as the work to be shouldered by the person who has yet to earn (both financially and in terms of respect and hierarchically) their right to parity and hence equality in all aspects of practice life. Out-of-hours cover could also to some extent be viewed as part of a GP's training. Since only a few of the women had participated in the relatively new mandatory Vocational Training Scheme, the length of time taken to demonstrate one's validity as a GP could vary depending on

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3 Their gender status also meant that they had less control over their work - this is discussed in chapter 7.

the practice and the senior GPs concerned. Some of the women interviewed had shouldered a very heavy responsibility in taking on a large proportion of the out-of-hours and 'on-call' cover for the group practices they had joined. For example, one woman joined as an assistant to a practice which had previously been a single-handed one and she quickly realised that she had been taken on solely to provide the out-of-hours cover. She was rarely in the surgery:

> .... it was really because he just wanted a little help and he didn't want anybody .... he wanted somebody to be on-call all the time .... all the visits I had to do and when I was in the surgery I hadn't much to do but had about 10 visits a day .... and the only way I got to know some patients was because of the visits and because I was on-call most of the time .... (no 5)

The amount of on-call work that women did as junior members of practices was to a large extent out of their own control:

> .... I was doing more and more and more work, and you know getting paid a very, very, very small wage and I, just one day I was absolutely totally fed up when I discovered I was supposed to be doing yet more on-call work that nobody told me about when I went for my interview ... (no 7)

Another GP spoke of her time in a group practice which on the whole was a satisfactory arrangement, where she had good relationships with the partners. However, she found the rota system, involving being on-call for the whole weekend, hard going. When she was also on-call for her hospital appointment[4] this compounded the problem in the practice because it

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4 This was one of the few GPs in the study who had a hospital appointment on the Hospital Practitioner Grade for GPs.

involved an extra day over the weekend:

> .... they used to moan they had to be on-call when I was doing my Friday, Saturday and Sunday at The Royal you know ... my day in the week for emergencies was a Friday, and when it came to your weekend it added three days instead of one, which was always rather wearing for everybody, but there were no rows as such.... (no 26)

There were several examples of junior members of a practice being given a larger share than other practice partners of on-call nights and weekends. One GP explained how being frequently on-call at night affected her home life and her husband.

> Though I was a salaried partner I used to do two nights a week, and when it was the weekend only ... two of them did the weekend (3 including her in a 5-person practice) so I used to do one in three weekends, so when it was the weekends it used to be four nights a week. In fact it didn't bother me at all because you know I can go to sleep any time, but it bothered my husband, it used to keep him awake, and second call comes, I used to sleep and then get up again and go and do the second call and that used to, but he used to still be awake, it upset his nights. (no 27)

The discussion of past practice experience where out-of-hours cover was concerned brought strong response from the women GPs. For the most part those who had been in groups and partnership practices in a junior or part-time capacity felt that they were covering more of the out-of-hours calls - night and weekends and other emergencies - than other practice members on the rota. Somehow, rotas did not necessarily work out evenly. The situation was at its most exploitative for junior GPs in smaller practices, i.e. two person partnerships, where the senior partner could/should use the junior for calls/visits while he (invariably he) would do mostly surgeries. The effect of this on partners in the home, where making night visits

disrupted sleep, was mentioned by several women. It was also found that working in a big practice with an equally shared rota system for out-of-hours calls could mean being on-call less often, but it was particularly stressful to take on responsibility for such large numbers of patients at one time.

Past experiences of out-of-hours cover in groups and partnerships seems to some extent to have had an effect on the way the single-handed women GPs organised their cover once they began to practise single-handedly. The effects could be positive or negative in that where past experiences had been good, and it was felt that out-of-hours cover had been well organised, then this was a consideration in how they organised their own practice cover. They tended to build on those positive experiences and, where possible, have similar arrangements. Where experiences had been negative, feelings of exploitation expressed and so on, then arrangements for out-of-hours cover as single-handed practitioners were different.[5] These arrangements are discussed in the next section below.

9.2 Out-of-hours cover in single-handed practice

Single-handed practitioners are solely responsible for their practices, 24 hours a day, seven days a week (see chapter 3). There were a variety of different strategies employed for coping with and handling out-of-hours cover. The various options open to doctors were outlined earlier in the previous section and these will now be examined in greater depth. At the

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5 There was much more discussion of respondents' feelings of exploitation and rather less of good arrangements for cover.

time of interview three of the women were covering **all** out-of-hours calls themselves (nos 4, 26 and 28); although some others had done so in the past, but had changed this later. For the three in question, who were on-call all the time, this meant 24 hours a day, seven days a week, all year. One of the three (no 4) had no choice as to how to organise this cover. For her there was no possibility of using the deputising services since they did not cover her area (deputising services tend to operate only in big city areas and conurbations - doctors in rural areas or small towns have to make other arrangements). In addition it was not possible for her to have a rota with neighbouring GPs because of her poor relationships with them. (More will be said about this situation later). A second GP (no 26), who did all her own out-of-hours cover, did organise cover by neighbouring GPs on the rare occasions when it was absolutely necessary. Another GP (no 16), who had used the deputising service for three years at the time of the interview, had before that been on-call all the time for the previous 30 years!

In any discussion of what it is like to be on-call constantly the notion of 'feeling trapped' is central. Most outsiders would certainly view the situation in such a fashion, although this was not necessarily a common factor in how the women concerned felt about their situation. One would expect that the lack of arrangements of support over out-of-hours cover would be very restrictive, but this is not the total story. As one GP described her situation:

> .... it is tying .... initially that was the one thing that frightened me, that I'd feel that I was constantly living under the cloud of being on-call, but I don't. (no 4)

The way she referred to her situation it was certainly difficult to understand why she did not feel "constantly living under the cloud of being on-call". A recent innovation for her had been to start using a bleep, but this still did not free her significantly:

> What I can't do is, I can't say, travel outside a half an hour travelling distance. There's a sort of confined radius that I can't go outside .... I live in B..... which is just further out into the country, and there's places like C..... where there are horse trials ... well, all that area is quite close but it's blacked out with my bleep .... because of the Pennines, you don't get a good reception, so there's lots of things that I wouldn't mind going to that I can't get to that bugs me .... I've got some friends over at R...., I've not seen them for 3 years now unless they come and see me. (no 4)

She described the situation before she had the 'bleep'

> .... it's not so much going to places, it's the travelling .... this I think is the big difference .... before I had the bleep .... it used to be a nightmare because, you used to set off and you'd phone up half an hour later, to check, and somebody might have rung, you know, five minutes after you'd left .... now, no matter where you are you can always turn back. So you see there's quite a big difference. (no 4)

In essence it is not relevant whether there are likely to be many calls to answer or to go out to; being on-call still means the GP has to be not only available at all times but that she has to completely limit other activities - whether related to pleasure, outings, work or domestic responsibilities. In effect, if there is no support within the practice situation for out-of-hours calls and visiting, then there needs to be support in the home in some respect. For example, two women out of the 29 had a form of 'role-reversal' in the home between themselves and their partners, so that their situation was most directly comparable to that of a man GP. These two

were both GPs who did all their own out-of-hours cover (nos 4 and 16).[6] For those two GPs support in the home in the form of role-reversal was vital since there was child care involved, a major consideration in how they organised out-of-hours cover. The other two GPs who did all their own out-of-hours cover had no children to consider (i.e. neither had been single-handed when their children were young). The domestic situation will be looked at in detail in chapter 10, but it is worth seeing just how the situation of being on-call does intrude into organisation of home life, particularly for those women covering all their own out-of-hours care. This will be considered later in this chapter.

The completely opposite situation from doing all out-of-hours cover for oneself was for the woman GP to hand over to the deputising service for **all** of this cover. The GP mentioned above who had been on-call for 30 years until the deputising service had become available in her area now used this service for all her out-of-hours cover. As she described it:

> .... until three years ago I was on-call every minute of every day and every night, and every weekend .... I did 30 years, I'd had enough. I was at breaking point. (no 16)

The deputising service had previously operated to within half a mile of her surgery but, although she "pleaded with them to let me pay", they would not allow it.

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6 See Table 9.1 and above for explanation of doctor 16's out-of-hours cover arrangements.

> Then suddenly three years ago they decided to take over H.... so I jumped at it and joined the deputising service .... (I use them) .... every night and every weekend. It's marvellous .... It's changed my life altogether. I was really waiting for retiring age, but now you just can go on 'til 90. (no 16)

This GP had reacted to her 30 years of complete responsibility for her patients and practice by handing over as much as she possibly could. It seems hardly surprising that she had reacted to her situation in this fashion, but the deputising service in effect is not meant to be used in this way, and few GPs were so completely dependent on it.

As indicated above, 19 GPs made some use of the deputising services to cover their out-of-hours calls. For the seven GPs using the services for all their cover, this (obviously) included every evening and weekends. However, several did have variations from this. For example, some said it depended how they felt at the end of a day as to whether they would take their own calls that evening and refer calls to the deputising service just during the night, or whether they handed all calls over from early evening after surgery hours:

> Well .... the cover is available .... each evening until 7 o'clock in the morning and each weekend, you can decide on any particular day whether you want them to cover you for that night or not .... so it's a perfectly flexible life, and I can suit myself and the family .... it varies, it depends on what I'm doing, what I want to go on, if I have a lot in the day and I can't take any more .... then I put them on call. (no 9)

Another arrangement was to have a rota with a neighbouring GP for some weekend cover in a reciprocal manner in order to avoid using the deputising

services more than permitted:[7]

> Well if I've got patients with particular problems I like them to call me but at night the deputising service takes over and at weekends but we're not allowed to put the deputising service on every night, so this is how I get round it .... the problem patients call me directly, and I'm in the phone book anyway, any patient can phone me, but on alternate weekends another single-handed male GP locally, he does alternate Saturdays for me and I do it for him, and the occasional Friday afternoon and evening if we want to get away for the weekend. It does help otherwise life would be impossible. (no 14)

Eleven GPs used the deputising services irregularly; some were very unspecific and casual in their explanations of their use of the services, while others used them at regular times. For example:

> .... sometimes I give it to the deputising service .... (no 2)

> .... if I'm out socially, or if I'm held up, because being on my own if I'm doing one visit and there's another emergency, I can't be at two places at the same time, so if it can't wait I ring the deputising ... (At night) I do use the deputising sometimes if I'm tired or if I feel like it. (no 19)

> I have an option, and use it when I feel I need to, and I use it sort of one weekend in three definitely, but I pay for the full commitments so that I can use it if I need to, say if I felt very tired or .... if I suddenly go home and feel I can't face going out again I just ring them up. You pay extra for that, but it's well worth it, than that awful feeling, god if I'm called out tonight, and you've really had a bad day. (no 21)

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7 GPs are not supposed to use the deputising services for all out-of-hours cover. FPCs generally grant consent to GPs to use them on a limited basis, to provide reasonable relief. 'Reasonable relief' is open to interpretation by individual FPCs. See discussion in chapter 3.

It is apparent that most of the GPs who used the deputising services irregularly and were unspecific about when they used them, were committed to covering some out-of-hours calls for the benefit of the patients, but liked the convenience of having the deputising service to fall back on. On the occasions when the GP is "very tired", "cannot face going out again" and so on, they were then able to hand over calls. The services are used for convenience on certain occasions rather than being viewed as a necessity in allowing them to practise single-handed. However, rather than being viewed as just a convenience, the deputising service can be seen to be improving the quality of life of single-handed GPs. Those GPs who were more specific about the frequency with which they used the deputising services, tended to use them as much as possible, viewing this as a necessity rather than a convenience. The on-call periods they covered themselves were to enable them to remain within the regulations regarding use of the deputising services. While this suggestion of motive was not voiced, it was implied:

> I try to do two nights a week, but the rest I give it over to the relief agency .... I don't do any weekends .... I give all that over to the deputising service. (no 5)

> I do use the deputising service, only for emergency night calls .... weekends .... alternate weekends .... only night calls I give it up to them, you see, day calls I do myself. (no 22)

Another GP who had a consistent policy about her use of the deputising services in fact used them very little but for specific purposes:

> Deputising service? Whenever I'm out, which is probably one evening a week ....
> (So you do night time calls ..... yourself?)
> Yes .... unless it's late at night and I'm afraid to go out alone.[8] (no 18)

Here again use of the deputising services is for convenience rather than necessity, to allow some free time, so that leisure, outings and so on can be uninterrupted. Although being on-call does not necessarily mean being called out, or even telephoned at all, the GP has to be available and it is relief from constant availability which they seem to value. It enables them to relax if they do not use the time in any concrete way, when it is known that the possibility of being called has been removed.[9]

It can be seen that demand for deputising services, even amongst those who rarely actually called on them was considerable. This demand for the deputising services was not a callous one. There is little question that the doctors interviewed cared deeply about the sort of services their patients

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8 This important matter is discussed later in this chapter.

9 The deputising services are, of course, staffed by practising doctors and several of the women interviewed had at some time in their careers worked in this capacity. One GP, for example, used the deputising service to cover her calls when she was working for them, which it appears she did for financial reasons:

> I do Medical Relief as well, which brings in quite .... they're very kind to me ... (no 6)

Others who work or had worked in the past for the deputising services also used it as an extra source of income:

> .... I was also doing a lot of deputising, I very much associated with the deputising service, and I wanted to do that full time for a few months to get some money really. (no 20)

were receiving. Since the care of the patients on their lists was wholly their responsibility, even when they handed this care over to others, it would be important to them that they felt confidence in those who took on this cover on their behalf. This leads, therefore, to further exploration of the deputising services themselves, and to suggest ways in which withdrawal of them is a gender issue.

The pros and cons of the deputising services were briefly discussed in chapter 3 and these will now be related to issues pertinent to this study and the women GPs in particular. It is appropriate, therefore, to explore the deputising services themselves, particularly in the light of the recent questioning of the standards of many of the deputising services and deputising doctors (Royal Commission on NHS, 1979). Since the services are run privately and are not an NHS provision, safeguards on standards of service provided and quality of deputising doctors are difficult to monitor. Each example of deputising doctors not providing adequate care for a particular case is used against not only the whole service, but also those doctors who hand over care of the patients to deputising services. While there may be cases of doctors working for the deputising services being those who have had difficulty getting other employment, it is hardly acceptable to suggest that the GPs who hand over care are responsible for this. Adequate provision for out-of-hours cover under the NHS would overcome many of the inadequacies of the deputising services. It seems unlikely that the present private system for deputising services could ever be scrutinised to a satisfactory degree to satisfy NHS expectations. Notwithstanding any questions of the standards of deputising services and the quality of care provided by deputising doctors, GPs put trust in these services to a considerable degree. It seems unlikely that they would do so if they did not feel their patients would be adequately cared for.

Should this questioning of standards lead to withdrawal of deputising services the consequences would be disastrous for GPs but particularly single-handed ones. GPs' dependence on deputising services is related to a number of factors, and not only the need for some time for private activities. While it is reasonable to suppose that some GPs who use the deputising services would be able to make some sort of arrangement by organising a rota with other GPs, there are many for whom this would just not be possible. It is more than just a lack of alternatives which is in question here, and particularly so for single-handed GPs whose alternatives are more limited than GPs working in groups and partnership practices. The withdrawal or further limiting of the use of deputising services, it can be argued, would be discriminatory in terms of gender.[10]

First of all, if deputising services were not available, all GPs would find that this affected their domestic situations and private lives. Any occupation or profession which requires a certain amount of out-of-hours (i.e. office hours) work has some effect on the domestic situation of its incumbent.[11] The issue in most professions is that of 'taking work home', but for GPs this is manifested in a different manner, in that for them there is the added factor of absence. While it is also true that other professions

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10 See following sections in this chapter.

11 For example, Spencer and Podmore (1984) discuss the effect that taking work home in the evening and at weekends has on the home/family life of lawyers - solicitors and barristers. They suggest that, although there is a normative expectation amongst lawyers, most particularly barristers, that taking work home is part of being in their particular profession, this undoubtedly has an effect on their home/domestic situation.

may require some absence from home, for GPs this absence is of a very specific kind and has a dramatic impact on the home situation.

9.3 Being on-call

If one examines exactly what being on-call involves for GPs then the impact on the domestic situation is clarified, as is also the suggestion of this being a gender issue. When doctors are on-call then they have to be always reachable by telephone; this has a number of implications which involve other people. For example, the use of a bleep involves having messages taken by somebody else. Even if there is a financial arrangement for the taking of messages, the GP must still always be able to be reached easily by telephone. With the use of an answerphone to take messages, it would be necessary for the GP to refer to it very frequently for emergency calls and this would really only be acceptable for times when the doctor was out on another call. Telephone calls outside normal 'office' or 'surgery' hours involve another person, who, almost invariably, is not financially recompensed for this intrusion and is most likely to be a member of the doctor's family or household. Being on-call involves other members of the family in decision-making on the doctor's behalf on occasions when the doctor is out. The person taking the call has to decide from the caller's demeanour the nature of action that needs to be taken, so that responsibility for the patient is displaced into the doctor's domestic environment. Another way in which the doctor's family can be affected by the doctor being on-call at night is that the spouse or partner can be disturbed by calls. If the doctor has to go out to attend a patient, the partner may feel uneasy in the absence of the doctor from home, until her return. This is probably a more important factor where women GPs are

concerned. A number of women GPs talked about the effect on their partners of night calls. In fact it could be more of a disturbance for the partner than the doctor herself:

> In fact it didn't bother me at all because you know I can go to sleep any time, but it bothered my husband, it used to keep him awake. I used to go and do one call, come back he used to be awake, and second call comes, I used to sleep and then get up again and go and do the second call .... but he used to be still awake, it upset his nights. (no 27)

Another GP, however, found that her husband was less affected as, with time, he grew used to the situation:

> it's been quite funny .... when we first met .... he used to take me on every night visit, and then we got married, and then he used to lay awake whilst I went out .... and now I've literally been out at night and he's not heard the phone! If he ever woke up in the morning and found I wasn't there he wouldn't know where I'd got to! (no 4)

The question of the safety of a woman GP going out alone at night is an important one in the way it affected the husband (leaving aside for the moment the woman's own feelings about this). The interviews were carried out at a time when the Peter Sutcliffe ('Yorkshire Ripper') case was fresh in respondents' minds. For GPs husbands this was a particularly worrying time:

> .... the only time it was ever of interest was whenever the Ripper was on the go .... when he did his last murder in Leeds, and Sheffield police were saying, ... it's our turn next, our turn next, and I must admit I got the wind up me drawers then, and J.... said, "Well, never mind dear, whenever you next have to go out I'll come with you," this was before I'd had N...., so the phone went at 3 in the morning and I had to go out and he didn't come with me, he sat and worried, and he was standing at the stairs when I got back..... (no 7)

This last women raised another issue of the way in which out-of-hours calls can affect the GP's family. It is implied that the birth of a child affected the possibility of the partner being able to accompany the doctor on a night call for the sake of safety and/or peace of mind. While some GPs did state that their husband had at times gone out with them on night calls, which is certainly an intrusion into the family life and husband's life, the option of doing this would be seriously curtailed if there were children to consider who could not be left alone. Since a majority of the women in this study had children, husbands had been left to care for them when the doctor was called out. If a doctor with children is on-call, it is necessary that provision is made for children in the event that she may be called out. Although a doctor on-call may not necessarily be called out, babysitting arrangements still have to be made. The person to babysit was usually the husband, of course. This rarely caused any particular problem but unless there were other adults who could be called on the **possible** need to babysit inevitably curtailed the actions of this husband. This in effect meant that when the GP was on-call, neither she nor her partner could go out.

Where no one was available to babysit, women had to make some other arrangement. This situation occurred most often where the GP was a single parent (although it can occur under other circumstances, too). One option (though hardly a practicable one) would be for the single-handed woman GP to take her children with her on those visits. One woman, who was separated from her husband, discussed how night visits affected her children when they were young:

> I never went out and left them on their own. I would take them in the car. In fact my youngest son, you know, when he was seven, he said, I'm fed up of doing house calls and I'm not doing any more! Because a few of the houses didn't smell very good and he has a terribly sensitive stomach so he would start heaving at the door and found it terribly unpleasant at times, but .... I never left them alone because I always thought, well, if anything happens to me while I'm out, well they would get into a terrible panic, so I wouldn't even cross the road and leave them alone. (no 18)

The burden on this woman (and her children) needs no elaboration.

The need to act immediately when a call comes through has a considerable impact on different aspects of the doctor's life and certainly affects the freedom of a doctor to care for her child. For example, one woman said.

> The number of times I've been in the middle of a feed and somebody's come in and said there's somebody urgent, can you come and see my child quickly, I've had just to plonk them down and go, you know .... (no 16)

The problems involved where childcare is involved will be considered in chapter 10 more appropriately under discussion of the GPs' domestic situation and children. Suffice to say at this point, children and husbands and other members of the household are intrinsically involved in the decisions GPs must make about how to organise their patients' out-of-hours cover. It seems inevitable that the family will in some way be directly affected by a doctor's responsibility for her patients' out-of-hours care.

9.4 Practice location and out-of-hours cover

Another way in which a doctor's domestic situation is directly pertinent to being on-call is in the proximity of practice premises to her home. The Acheson Report's (1981) criticisms of lock-up shop premises (see chapters 3 and 8) were not just related to their structural and decorative conditions and facilities, but to the fact that such premises and practice catchment area were often at some distance from the doctor's home. Doctors often lived too far from their practices to cover them for emergencies at night. Therefore, the Report suggested, such practices were usually served by deputising services for all out-of-hours cover, most particularly at night and weekends. As indicated above, the questioning of the standards of deputising services and deputising doctors, raises the question as to how out-of-hours cover should 'ideally' be organised.

However, the implication that the proximity of the GP's home to the practice premises is linked to use of deputising services is a spurious one. For example, of the three doctors who covered all their out-of-hours calls only one had her practice attached to her home. Of the 11 GPs who had their practices attached to their home, 10 made use of deputising services and rotas to some degree, and some quite extensively (two of them using the deputising services for all out-of-hours cover). Moreover, of those who did not live on their practice premises, although use of deputising services was greater, it did not seem to be very much greater, and the relationships should be viewed as tenuous. Unfortunately, no information was collected on distance of doctors' homes from practices which would have strengthened findings on the relationship of home and practice location and use of deputising services.

Respondents were asked how they felt about living amongst their practice community and views on this were mixed.[12] One woman (no 20), for example, talked about wanting to have a separate life from the practice, and the thought that patients might knock on her door or that she might see them in the shops made her feel she needed to live outside her practice area. Others were quite happy to live amongst their practice community and were not bothered by such contact with patients. However, it should be recognised that the reason for the existence of many lock-up shop practice premises is that GPs do not want to live in the working class areas where many practices are located. This discussion is intrinsically related to use of deputising services, although not clearly so amongst this sample of GPs. It is a problem that would seem difficult to overcome, unless stipulations are made about the distance GPs may live from their practice premises. This could well have the effect of leaving large areas of dire need without adequate general practitioner provision, if GPs move their practices nearer to where they live.

9.5 The gender implications

This concluding section will discuss gender as a factor in out-of-hours cover. This has been raised in this chapter in relation to the deputising services and being on-call, but the implications of gender on out-of-hours cover and with respect to home visiting will be considered. If one draws out of the discussion the way in which a GP's being on-call affects other

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12 This is one aspect of the 'ideal type' traditional GP's doctor/patient relationship discussed in chapter 1.

household members, both adults and children, then it can be seen that this is directly related to gender. Since women for the most part take on a major responsibility for home, husband and child care, with varying amounts of support within the home (Elston, 1980), then how they organise their out-of-hours cover is clearly a gender issue. Certainly for the women GPs interviewed in this study, as will become clear from discussions in chapter 10 on the domestic situation, the amount of responsibility most of them took on within the home would be prohibitive if they had not made adequate alternative provision for out-of-hours cover. Added to this is the relationship within the home between doctor and husband and profession. In the traditional ideal-type 'family doctor' practice it was usual for the doctor to be male and for his wife to be intrinsically involved in practice life particularly when, as was usual, the practice was attached to the doctor's home. The wife acted as secretary cum receptionist cum telephone message handler as a matter of course and support of this kind from within the home was expected and necessary for a successfully run practice. For men GPs the situation has changed in that, while fewer of them have practices attached to home, more wives work outside the home and are less available (and perhaps less willing) to provide such support. However, it is still regarded as an intrinsic part of being a GP's wife, and support of this nature is still often provided extensively. For the woman GP, however, the situation is different. Most women GPs are married and their husbands have professional careers, which require considerable commitment over long hours. This means that a woman GP is unlikely to have a partner who can offer the same sort of support that a man GP would expect. It is, moreover, not traditional practice to have the husband acting in a supporting role to a woman. Hence, husbands tend to be less supportive both in the domestic set-up and to the professional role;

consequently the woman GP seems to lose out as far as expectations of support is concerned. While it is 'traditional' for women to support men's careers, the reverse does not apply.[13] In fact, it was rare for the women GPs to have totally unsupportive husbands as far as message handling and so on was concerned, but there was some indication of resentment on the part of husbands. One woman (no 12), for example, felt that her husband would like her to give up practising altogether, partly because of the involvement he could scarcely avoid having with her patients, however much she tried to keep the practice and patients out of his contact. This sort of difficulty is inevitably more pertinent for the single-handed woman GP, because the home and family/professional intermingling is so much greater than it is for GPs in group or partnership practice.

The gender of women GPs becomes a major factor when looking at how they cope with and handle home visiting, both routine and emergency, and day and night calls. While there may be problems for **any** person who has to enter someone's home for professional purposes, risks that may be being taken are for the most part small.[14] For a doctor visiting patients routinely in their homes, the professional status relationship built up in the surgery consultation is transferred into the home, which should mean that the doctor can 'hide' behind that professional status and role. The relationship between doctor and patient is mediated by variables such as class, gender, age and ethnicity of both doctor and patient. Other

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13 See Finch (1983) for a discussion of other professions which depend on the support the wife gives the husband in his professional capacity.

14 There has been concern about female social workers visiting clients alone, particularly since the recent murder of a female social worker in Birmingham.

associated issues in this relationship can be such things as fear of illness, resentment, the patient being on home ground rather than the doctor's surgery and so gaining in confidence and so on. Suffice to say, despite these intervening variables, the doctor is usually safe in what could be unsafe situations because of **his** professional status and aura of professionalism. However, all doctors are not white, middle-aged, males. A **woman** GP, particularly a **young** woman GP and/or of different ethnic origin, is at greater risk since she does not fit the common stereotyped image of 'the doctor'.

Literature on the professions, which is supported by the findings of this study, suggest that the older woman is unsexed by her age and consequently at much less risk, in that she conforms more closely to the professional image (Marshall, 1984). Risk to the person may be greater at night than during the day. This could of course be related to the fear element mentioned above, since a night visit is more likely to be an emergency than a day time visit. Problems of night visiting are also related to fears any woman may have of being out at night. Many of the women GPs were loath to go out on visits at night. While only one GP interviewed had actually been physically attacked and harmed (no 24), many others related frightening incidents which they had experienced, and others felt generally uneasy on night visits. The fear of physical violence or assault and the feeling of vulnerability not only relates to night visits, since problems can occur during any consultation either in the home or the surgery, or at any time when the doctor is out. However, it is on night visits that feelings of vulnerability and fear are paramount. The time when the woman doctor seems to feel at most risk is not during the consultation in the home itself (although incidents were related) but when travelling, walking from car to

house or block of flats, using phone boxes and so on. This is also the time when the doctor is not recognised by an outsider as a doctor and is therefore not in a position whereby she will be protected by her professional status.[15] In a smaller, rural community the doctor is most likely to be known out of context of her surgery, but most doctors in this study did not practise in such communities, most were in towns and cities.[16]

Only one doctor interviewed had actually been physically attacked while out on a visit. She had twice had her car broken into and had once been in hospital after having been knocked unconscious whilst out on a night visit;

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15 The idea of professional status as a doctor being a form of protection was well demonstrated in discussion with a woman who related her experiences of being a young doctor during the Second World War:

> I mean we went everywhere in the dark in the blackout, no headlights, and all in tenement buildings and we used to walk ... and I said to my friend, I can't do that .... and she said, yes you can .... you and me and the midwife are absolutely sacred to these people, they need us, they need us desperately. She said, we are guarded and watched from the time we leave here to the time we do the job and come back again. I was terrified. And as you went down these alleyways and up these tenement blocks, five or six stories up these tenement blocks, you never saw a soul, but you knew, you sensed there were people all around you, and you were guarded until the door opened and let you in where you were going, because they only sent for you when they needed you.
>
> (So you never did face any trouble?)
>
> Never had any trouble, we were as safe as the Bank of England, it was absolutely marvellous .... wouldn't work there now .... (no 26)

16 22 practised in large towns and cities, and 7 in small towns or rural areas.

consequently she remained very nervous about night visiting (no 24). One ploy which was used to overcome nervousness by several of the doctors was to take a dog with them in the car. This acted as both a protection to themselves and as a guard for any drugs they might be carrying. The whole issue of feeling apprehensive about night visiting is well illustrated by an incident related by one doctor:

> I remember once, years ago, when I first started, I was out one night .... and there were no lights in H.... in those days, it was ever such a poor night light, you know, the street lights, in those days we had no lights at all. At about 11 o'clock at night I'd been called to this house, an isolated spot .... it was a baby boy and I'd got to get him to hospital straight away, no phones in the house in those days, I'd got to walk to the end of the street to phone on an isolated patch, so I went to the call box, and it was you know like a broad pavement, and the rest was gravelly, the phone box was set in gravel. I'd just dialed this number, just going to speak when I heard footsteps getting nearer and nearer .... I froze .... and suddenly the door opened .... it was a policeman .... he was wanting to know what I was doing there, they didn't know me you see ... that time of night, about 3 o'clock in the morning .... (no 16)

Different strategies for dealing with fear of incidents occurring when out on visits were employed, some quite intricate. One said:

> If a patient I don't know very well rings me up for a night call, I won't go. If I know them very well I tell them to wait outside their house, so that they meet me at my car, and .... sometimes they offer to come and collect me. If I know them very well they might do that, but I'm very aware of the fact that, you know, GPs get mugged and this sort of thing, and I haven't had many calls but I've had two, you know, men trying to get me out to visit them and I realised that it was hoax because the addresses they gave.... (no 18)

And another:

> I used to be always frightened about somehow coming into the garage .... I used to leave all the lights on, you know, and drive in .... that's when I always thought somebody was lurking when I came home. I was never worried about going to the particular house .... I don't think I'd like to go now, to a night visit down some of these flats that I've got on my list at night, without somebody waiting .... If I drove in I'd drive to the door and expect them to be there, but I wouldn't like to go to the flats on my own.
>
> (Then would you call out the deputising service?)
>
> I'd either call the deputising service or take my husband, or ring and tell the relatives they've got to meet me somewhere. (no 21)

As suggested earlier, it is not only night visiting that can create problems.

During the day there may be problems in 'insalubrious' practice areas:

> (And it doesn't bother you during the day?)
>
> No it doesn't bother me at all, except one area of N..... and there I go with my husband, or else I just don't go. I tell them to meet me at the corner, some .... reasonable place, and then go in with them.... (no 12)

Several GPs mentioned using the police to help them on difficult occasions or accompany them on night visits:

> I think the best thing would be to inform the police and get a police officer to accompany you, if you think there's going to be problems. (no 5)

And as mentioned previously, some doctors had their dogs accompany them on visits:

> I mean sometimes I put the dog in the car, if I'm going to a really ropey area, and I think he'll guard my bag or you know drugs. (no 6)

> I always used to have my dog with me .... I think most women have a dog with them in the car. The doctor who does my calls sometimes at weekends, she's a lady and she has a dog, a lovely dog. I think they give you warning when you go to a house .... even when they come to my garage at night .... also guards your drugs in the car .... you should lock the car, but then again you don't need to if you've got a dog. (no 3)

All problems of violence by patients are not related to gender of course. All GPs/doctors are at risk to some extent. One woman said:

> I have had scissors held at my neck, when I went to see a psychiatric patient. But I mean that wasn't at night. I suppose, you know, everybody's going to have some sort of crisis with patients sooner or later. At night people are usually extremely helpful to you, give you coffee and .... (no 28)

It must be noted that, for some of the women, going out at night seemed to be no problem at all - they were not frightened nor had they suffered any alarming incidents. Gender did not come up as an issue for them in home visiting:

> .... it never bothered me, you know, I have, you know, 3 o'clock, any time of the night I have got up, when the patients telephone I think nothing comes to your mind, and most of the time you know the patients, and specifically I find now in single-handed practice you know most of your patients, it is much better than in group practice really. (no 27)

However, most of the respondents discussed night visiting particularly in negative terms and many of their comments were clearly related to their gender. Some fears were related to incidents which had occurred in their

experience, whilst other fears were generalised and stemmed for the most part from social attitudes to women and feelings of vulnerability as women.

This chapter has highlighted the issue of gender in relation to out-of-hours cover and home visiting, and how this part of the doctor's professional life intrudes into the home life. The fluidity of the public and private spheres of the doctor's life is demonstrated and the gender dimension is clearly apparent.

There are other problems than providing out-of-hours cover for the woman GP in attempting to marry her professional and domestic lives together. The following chapter, examines the domestic lives of the women GPs and analyses further the interaction of the home and professional spheres.

CHAPTER TEN

GENERAL PRACTITIONERS AT HOME: THE DOMESTIC SPHERE

Having considered out-of-hours cover as a gender issue in its link between the public and private spheres of the GP's life, it is pertinent to look more closely at the women GPs' domestic situations (or private sphere) and how these are reconciled with their professional or the public (social) sphere of their lives. While the notion of dividing women's lives into the 'public' and the 'private' spheres can be shown to be a false one - this has been demonstrated in various studies (e.g. Garmarnikow et al, 1983a) and is evident from the data presented in this one - it is a convenient shorthand way of expressing and simplifying a complex set of ideas. As determined in Chapter 9, it is impossible to speak of either professional or domestic aspects of respondents' lives in isolation, since they interact in so many ways; however, aspects of their domestic/home lives will now be examined in some detail. This includes looking at role reversal; support within the home; children and child care; children and career; and 'failed' marriages and medical husbands. Some parts of the discussion which follows have already been raised in the context of out-of-hours cover and the link this brings between the professional and domestic lives, but all these areas will now be examined in greater depth.

10.1 'Role reversal?'

The conventional, traditional organisation of family and home life is rarely challenged to any significant degree by women who work outside the home. Rather, women typically attempt to combine their domestic roles with their paid employment. Even those with full-time, demanding professional jobs, make few concessions to their work roles in their domestic situation (Spencer and Podmore, 1984). If compromise is made it is often made in the career role rather than in the family role. Varying amounts of support are given to professional women in the home, but it is a rare situation in which role reversal between partners occurs.[1] The whole area of compromise where women are concerned in terms of work, career and home life are questions which are raised throughout the study. Lorber (1984) looks at the question of compromise for women doctors in the USA. She suggests that, for male doctors, the problems presented where home life is concerned, and particularly children, are mostly financial (see below) but:

> for women physicians, the problem is the allocation of time. If there are compromises to be made in spending time at work or with children, they, rather than their husbands make them.
>
> (Lorber, 1984: 93-4)

However, there are examples of women doctors who do not have to make compromises of this sort (although compromise is an emotive and subjective word, since role reversal may be viewed as a compromise where

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1 Role reversal is taken to mean reversal of traditional roles between home and career i.e. man - homemaker; woman - career.

home life is concerned). There were two examples of role reversal in this study, although both were the result of circumstances rather than by design or for idealistic reasons.[2] It is questionable also whether role reversal can ever be the perfect solution since it is not based on the concept of **sharing.** Nor is it based on an idea of the interchangeability of roles between partners and between work outside the home and domestic or housework. Rather, role reversal perpetuates the concept of patriarchy and is important for furthering an analysis of patriarchy. The traditional patriarchal arrangements of male breadwinner and female home-maker and child carer are not in fact turned 'on their head', but act as an extension of the notion of patriarchy by perpetuating the traditional division of labour between home and work in reverse. In fact, the two doctors cited in this study can hardly be used to demonstrate 'patriarchy-in-reverse' but are more clearly instances of 'patriarchy-extended', as the examples below make clear.

In neither of the two examples of role reversal was there total reversal of role for the traditional division of labour within the household. Both women and men in these two examples clung on to their traditional roles to some extent and this occured partly because of the way in which role reversal had been chosen. In one case (no 4) role reversal had been chosen for financial reasons, in that the woman's earning power was substantially greater than that of her husband. In the other case (no 16) role reversal was very limited, as will become clear later; it certainly did not cover

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2 Neither had decided to follow this course with the idea of promoting the woman's career in favour of the man's - it had "just worked out like that".

childcare in the early days when the children were young. At that time the doctor had had complete responsibility for the care of her children.

The issue of role reversal can best be examined in the form of a detailed description and analysis of the experiences of the two doctors involved. In this way many of the aspects of the division of labour between partners will be exposed for discussion in later sections of this chapter in examination of the domestic arrangements.

Doctor 4

She was 34 years old, with a small town practice and one child, aged three. The practice list had 2,000 patients; she had previously worked in a partnership, which she had left because she and her partners had not got along very well. She lived with her second husband who had owned a small shop in the village in which they lived (her first husband had been an engineer). The practice was not attached to her home. She covered all her own out-of-hours calls. This marriage is included under the category of role reversal because her husband was at home while she ran her practice. He gave up his shop largely for financial reasons when the lease on it expired. At that time this seemed the most financially expedient way of proceeding. Role reversal is often viewed as a way of solving child care problems, but in this example this played a minimal part in their decision for the husband to stay at home. In fact, their three year old child was mainly cared for by grandparents and had been since birth. This had continued to a large extent despite one parent being more available in recent months. The husband inevitably took on more of the childcare than the doctor did since the change, along with housework, shopping, cooking

and so on. However, rather than a total reversal of roles many of the domestic tasks were shared, although his responsibility was greater. For example:

> (he takes on) ... total responsibility now for the housework, yes .... it's a mixture really, I tend to buy the food because I happen to be close to the shops ... in any case he's different, he'll buy them when we run out, whereas I like to buy them before, you see. Cooking, he probably does 3 or 4 nights a week, and when I'm ... when I have half days, I have a half day on a Tuesday and Thursday, I'll cook. But there's no .... definite line as to who does what.

The change of roles was quite difficult from both their points of view, since before he had given up the shop she had carried out most of the household tasks, as well as having the long hours of commitment entailed in running her practice. For example, she found it took her quite a long time to start to feel comfortable about giving up some of her domestic responsibilities:

> He doesn't do bad .... he doesn't do it quite as I'd like it .... but he doesn't do bad....

and

> We're different ... he leaves something a day or two, but I'd be doing it today ... but it's got easier actually, it used to bug me at the start, I used to go in and check each day to see if it'd been done ... now I don't bother.

Having her husband take over the cooking was another area which needed some adjustment:

> .... housework wasn't so much a problem .... the cooking, I mean previously he never cooked, and so he gave up work, and then he got the cookery books out and he sort of tried the odd exotic dish every now and again .... my first husband never cooked at all.

And as she continued:

> I always did every role until this .... until now, since June (i.e. 6 months)

This included looking after the finances, paying bills and so on, which in the traditional household can be done by either husband or wife (even as 'breadwinner' the man in some households hands over money for bills, etc, to his wife). Despite her husband's taking over a large amount of household tasks she did not feel that this particularly affected the amount of strain she was under:

> It hasn't made that much difference .... no, it's not made that much difference really. Since he's become a house husband? Well I don't have the cleaning to do, it's nice not to have that, but .... we paddled along in our own way before, I mean he helped me out before, perhaps not quite to the same degree as now, but no, it's not made that much difference. The lifestyle changed before that really, the change came when the partnership split up three years ago.

So, the change in organisation of working life, by going single-handed, had a much more significant impact on her than change in organisation of domestic arrangements. This may have something to do with the implications that can be drawn from her talking about her husband "helping her out". Does this mean that the work he did in the house was still done to help her, rather than being at his instigation? He was, however, very supportive where her out-of-hours calls were concerned, all of which she covered herself.

Doctor 16

She was 59 years old, with three children, all now adults. The practice list was 1300 (down from a previous 2000) patients and she had worked single-handed for 30 years, having previously worked for one year as an assistant in a practice. She lived now with her second husband, an accountant (having been divorced from her first husband, who was also non-medical). The practice was attached to her home and she covered all her own calls until the last three years, when the deputising service had taken over in her practice area. She is included in the category of role reversal because her husband ran the home and acted as receptionist/assistant for the practice too. He had given up his job as an accountant around the time of the birth of their second child (her third), with the intention of setting up on his own as an accountant at home. The intention at first was that he would be able to help look after the children, especially since he was not very busy initially with his accountancy. The change in lifestyle had been gradual and due to circumstances:

> I used to have a woman sort of answer door bells and things but she wasn't very good at it, so then my husband took over altogether, he did have a few clients .... And eventually after a few years he packed that up altogether .... and he answered the door bells for me, so we just managed.

The husband in this case, then, had taken on many of the traditional tasks of the doctor's 'wife' in the traditional single-handed practice, in acting as receptionist and answering the door to patients. (He answered the door to me when I arrived for the interview with his wife). In the home, he took on a large proportion of the household tasks. For example:

> My husband does the cooking, shopping, just nips up town in the morning; for that half hour, I have to answer the door if anybody comes ....

However, he did not do cleaning since a woman came to clean three times a week. The following demonstrates just what their respective roles were:

Q So he really takes on the domestic side ....?

A Yes, um, apart from cleaning ....

Q But you have someone to do that ...?

A Well a lady comes three times a week.

Q So you don't actually have to cope with the two jobs of running a home and ...?

A Well, I run it in as much as I organise things, what everybody does ...

Q So your responsibility is organising what everybody does ...?

A Yes, yes. Any other shopping, like shopping for clothes and things like that, I have to do that.

It is apparent that although in initial discussion the GP had intimated that there was a considerable amount of role reversal between her husband and herself, in essence the **responsibility** for the household was hers.[3] If one goes on to look at childcare - this had been completely her responsibility except for baby sitting when she was not available. (All this, of course, was many years in the past.) As she said:

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3 See Spencer and Podmore (1984) for similar findings on women lawyers i.e. that women had responsibility for organising actual tasks. See also Lorber (1984) on women doctors. See also Gerber (1983).

> I've always sort of brought the children up as well, you know ... bath them, feed them and everything you know. The number of times I've been in the middle of a feed and somebody's come in and said there's somebody urgent, can you come and see my child quickly, I've had to just plonk them down and go, you know ....

It is apparent that the husband's role in both child care and the household tasks was one of support rather than full responsibility - stepping in and following instructions when required, rather than instigating or taking complete responsibility for it:

> I mean he agreed that it would mean that we'd not have anybody else to look after the children, and it would be nice and things like that. And if I couldn't do it, then he would, you know, cleaning, washing and that sort of thing .... you can never trust anybody else anyway.

Another important aspect of taking on any of these duties, and particularly in cases of 'role reversal', is how the two partners feel about their non-traditional roles. For example, doctor 16's husband seemed ambivalent about it, since although the decision to practise accountancy from home had been his (as had giving it up altogether) the domestic side of the arrangement seemed to be less satisfactory as far as his self-image was concerned. As the doctor said:

> I don't know, I don't think he's ever quite accepted it. He's got used to it, I mean he .... more or less agreed to do it in the first place, wasn't pressured to do it .... But I think he feels mainly ... he goes out every night, to the club, and he's got the feeling that p'raps he thinks he's been .... not exactly .... but feminised a bit, you know?

It is apparent from both these cases that what is of most importance is not the actual roles people play in the household, but the feelings that

respective roles engender. Doctor 16 seemed still (after 30 years) to be taking responsibility for organisation of the home, while her husband was loath to take on too many of the things which would affect his 'masculine' image. He constantly sought to reinforce his maleness by seeking male company in the evenings, every evening. Doctor 4 seemed to find giving up her traditional role in the household difficult and tended to check up on her husband's performance in the tasks he was doing, while he was worried about the idea that people would view him as 'living off her', the implication being that they would be questioning his male image. Doctor 16's situation was, however, very much more typical of the traditional single-handed GP's practice-home situation, where it was the GP's wife who took on the administrative/clerical work of the practice (see Chapter 1). In this case, the husband mirrored the wife's traditional supportive role in practice, although less so where household tasks and child care were concerned. In neither of these cases did the husband appear to take on major responsibility for child care, and in doctor 16's case, he took a very secondary role in this.

In conclusion, further light can be shed on these role reversal doctors and their partners by reference to McKee's study of the effects of male unemployment on the family (McKee, 1983; McKee and Bell, 1984). In this study, she shows how "male unemployment can serve to **polarise** the experience of men and women ...." (McKee and Bell, 1984:140). While many men took a more active role in household tasks and child care when unemployed, there were those who used strategies to perpetuate and strengthen their maleness - their 'macho' image - for the sake of both wives and other social contacts, an image that was often fostered by wives too (McKee, 1983). Certain parallels can be drawn between McKee's study and

this one where it seems that women doing 'men's jobs' can be loath to let go of their own 'feminine' identity in terms of keeping a certain amount of responsibility for aspects of home and child care even in cases of partial role reversal when the husband is at home.

These two examples of role reversal brings out a number of issues of relevance in normal day-to-day relations between couples, where the wife has a full-time professional career to sustain. Further discussion of the domestic situations of the other 27 women GPs follows. More detailed examination of several of the issues raised above will show how the organisation of home life is crucial to successful performance in the professional role.

10.2 Support within the home

The other 27 single-handed GPs had varying but more traditional domestic arrangements. Only one had remained single, i.e. did not admit to having lived 'as married' at some stage of her working life, and most (20) were living 'as married' at the time of interview. Therefore, 28 of the 29 GPs were able to relate how they had managed a domestic relationship and reconciled this with a working career in medicine. Those who were living or who had lived, in a 'marriage' relationship (excluding the two role reversal and the single woman) expressed overwhelmingly the feeling that they took greatest responsibility for organising home, husband and childcare within that relationship. This is not a surprising revelation and is in line with many other studies which have suggested the traditional nature of the division of labour between partners within the home. Some recent research has developed an understanding of the nature of women's domestic

sphere and its relationship to paid and unpaid employment and the part played by men in this. Amongst this literature are studies looking at working women generally (Yeandle, 1984); working mothers (Sharpe, 1984); women managers (Marshall, 1984) - one amongst several studies of women professionals; and women physicians (Lorber, 1984). All of these studies make clear the major role played by women as far as responsibility and organisation of home, husband and childcare is concerned. As already stated this is no less true of the women in this study. The difference here, however, is the extent of involvement required of these women bearing in mind their professional practice as single-handed GPs.

There were several factors which affected the extent of responsibility within the home. For instance, while the women GPs were working single-handed at the time of interview, the wide age-range (29 - 68 years) meant that they were at different stages of the life and family cycles. This is most pertinent, of course, in respect of child care. It was apparent that while their children were young few of the women had worked in single-handed practice, so that these GPs are discussing different stages of their lives. Consequently, some GPs had different working arrangements to their present single-handed ones to reconcile with home and family organisation.

In discussing the areas of responsibility in the home, the amount of support that was available to them and how this support was expressed, it is apparent that responsibility in the home varied over a whole spectrum. For example, at the extreme one woman said:

> It was entirely my responsibility. My husband never believed in women's work .... he didn't believe in helping in the house. He couldn't break an egg ... He was always served at the table. Even the tea he wouldn't pour from teapot to cup. (no 1)

While this example was unusual in the extreme to which the husband's domestic role was circumscribed, there were examples where husbands were said to take an equal share of the household tasks but where a closer examination showed a less than equal division of labour.

It was common for the women GPs to **claim** that work in the house was shared, when in fact it appeared that they had overall responsibility, with husband giving some help. As one doctor said, organising the house was clearly her responsibility:

> but my husband does help. He's a very good cook ....
> (no 19)

This is a fairly typical sort of comment. The implication in this example is that on the occasions that the husband cooks, he is good at it, but that he does not do it very often.[4] Cooking is one of the household tasks that was mentioned frequently as an area where husbands would step in from time to time to help. For example:

> My husband is very good with cooking, he sometimes prepares the dinner for when I come home, it's just that it's not very often. (no 12)

Cooking was also something which took place as part of husbands' contribution to child care. One Asian husband, for instance, was willing to

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4 It is often held that anyone can cook a good meal if it is only rarely done - it is the day to day cooking that is particularly burdensome.

cook the children's supper, while his wife was in her surgery, but then expected her to cook his own (more fancy) meal for him when she came home:

> .... my husband when he gives the children food he usually gives them very quick English meals, which the children love, but he himself wants Indian food of course, which he doesn't like to eat very early, so that I go back .... (and) I cook for him.... (no 11)

And in the same example, it is clear that it is the cooking that the husband takes on:

> So he finishes (work) around 4 o'clock and by quarter past, half past four he's at home, and then my children come from school, and he s available, so he gives them tea and everything ... In the evenings, most of the time, ... and when I'm off after (surgery) I do everything. And during weekends most of the time I do all the cooking and washing and everything, but I get an awful lot of help from my husband. (no 11)

The contradiction in her comments is clearly apparent. Taking on tasks like cooking was most often done to help the wife on odd occasions:

> .... one Tuesday in four or five or whatever he'll be at home at four o'clock and he'll cook the meal. If I say can you cook such and such, he'll do it for me .... (no 7)

Other ways in which husbands helped with cooking was to start preparing the meal so that the doctor/wife could complete it when she returned from evening surgery:

> .... I mean if I'm late back for any reason, say when I'm late back on a Monday, sort of it's 7 when I finish, if I'm late back he'll start and get the meal ready and this sort of thing. He doesn't have to be chivied and bullied into doing it. (no 9)

Another husband who was a 'very good cook' was helpful in the same sort of way:

> If he gets in before I do, then he doesn't sit back and read the newspaper, he gets on with it 'til I get in. (no 19)

It is apparent on the whole that, where husbands help out at all, it is with cooking. However, it is rarely something that they take charge of.

So while some husbands/partners do contribute to cooking, this is seen by them to be an aspect of the domestic work in which they are **helping** the wife. Cooking is in fact a more 'creative' aspect of household tasks and more socially acceptable as a male activity than others such as cleaning, washing, ironing and so on. In being more socially acceptable as an activity a man can do, it is something that is more positively reinforced by friends and others than the more mundane household tasks.

If one looks then at husbands' contributions to other household tasks it is possible to see how these are distributed between household members. When tasks are categorised according to how 'creative', 'immediate' or 'rewarding' they are, it can be seen what makes some tasks more appealing to perform than others. For example, if cooking is categorised as 'creative', vacuum cleaning and shopping (see below) as more 'immediate' and child care (see below) as most 'rewarding', then a typology of attraction to household tasks can be drawn up.

The 'creative' task of cooking has already been discussed. Looking then at the most 'immediate', by which is meant most immediately visible, and most immediately gratifying, vacuum cleaning ('hoovering') and shopping are both examples of tasks in which a small amount of effort can quickly bring both gratification and achievement. Several doctors mentioned that partners would vacuum a room as a form of support. One doctor, for example, had a 'daily' women in to clean, but her partner helped her at weekends:

> And even at the weekends, if the house is in chaos and has got untidy, because my daily's not in Saturday and Sunday, **my husband thinks nothing of taking out the vacuum cleaner and vacuuming the house.** (emphasis added) (no 12)

Shopping was also done as a form of support. Many different shopping arrangements were mentioned. In some cases the woman did all the household and food shopping herself; in others (very few) this was reversed with the husband doing it all; in others the task was shared with partners doing a big supermarket shop together; while in others the husband bought items as and when requested. In all cases, the woman took overall responsibility for shopping for the household, and where the husband 'helped' this was done under the doctor's instructions, some husbands apparently requiring more specific instruction for this than others. A typical sort of arrangement for shopping was:

> I do the shopping. My husband does some of course, some of it on Saturday morning, when I have surgery, but .... that's not very much, I do the bulk of the thing. (no 5)

Other household tasks such as cleaning, washing, ironing, and so on were for the most part the responsibility of the woman, and few mentioned husbands who participated very much in those areas. It was common to have some form of domestic help, particularly when children were young (sometimes live-in to help with children), to assist in all areas of domestic work, but most commonly for cleaning. However, an important point in this discussion is that since these areas of household work were the doctor's responsibility, for the most part, it was up to her to organise any assistance she might require. For example, "I have somebody come in and clean" (emphasis added).

What is evident from the above discussion is that most women expected to take on overall responsibility for the home, that many looked for assistance from husbands and this was forthcoming in most cases to varying degrees. However, few husbands took much initiative where household tasks were concerned, particularly those which were traditionally performed by women. Most of the doctors, though, put over a view of a very supportive husband and of a household where tasks were equally shared.[5] This aspect of role division/division of labour within the household is described by Lorber (1984) as an 'egalitarian overlay' which in fact disguises what is really a traditional division of responsibility. By this Lorber means that it is the wife/doctor who takes on major responsibility for **planning** in the household and who is the initiator of household activities in whatever form. Where husbands participate it is invariably at the instigation of the

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5 Just as it is a problem in interviewing that respondents try to show themselves in a good light, so they try to show those close to them, such as husbands, in a good light.

woman. This adds to the load on women, who feel that they have to oversee the tasks which they have delegated. This comes over clearly in the 'role reversal' examples discussed above, but it is evident in other cases too. To reiterate one of the 'role reversal' cases quoted above:

> He doesn't do bad .... he doesn't do it quite as I'd like it but .... he doesn't do bad ... I used to go in and check each day to see if it'd been done ... (no 4)

10.3 Children and support

The case of childcare and the amount of support women have is a good example for demonstrating Lorber's thesis (1984) that women are the 'planners' and organisers of tasks performed by and for members of the family or household. The notion she proposes of the 'egalitarian overlay' of the division of responsibility within the household is clearly demonstrated as far as the single-handed women GPs in this study are concerned.

Because childcare is the most usual reason for women to voluntarily give up working outside the home (it is rare now for women to give up work on marriage) it is clearly viewed as women's responsibility in the very earliest days after birth. This is the time when a pattern for the later behaviour between couples is forged. It may be a time when the husband helps out in all sorts of ways in order that the wife can concentrate on caring for the baby (particularly during the time when she may be breast feeding), but it is a time also when habits are formed, when the mother, in spending so much time with the baby, inevitably makes decisions about its every move. Such habits may be difficult to break so that where support is forthcoming it is commonly just that, support or assistance rather than responsibility.

In this study, 26 of the 29 women had had children (of whom one had stepchildren).[6] Because of the wide age range of the doctors (29 to 68 years) the child-rearing ages come more clearly into focus when looked at in Table 10.1 where the range of life-cycle comparisons become apparent.

It has already been clearly shown earlier in this chapter, that childcare, amongst the variety of family/household tasks is by far the most popular amongst husbands. This was where they were willing to give the support most readily to help out. Spencer and Podmore (1984), for example, have shown how men were willing to play with children, or bath them or put them to bed and so on, in order that the wife could get on with her other household duties, such as cooking and washing and so on. While this may have been true for the doctors in this study, it was not something that was specifically stressed, or discussed in any conclusive way.

As already indicated, Lorber's (1984) notion of women as 'planners' in the household is a highly relevant aspect of the organisation of childcare in this study. By this is meant that it is the woman's job to think and plan for her children, and to arrange for their care. While some of this care may be performed by the husband, this is invariably time that has been negotiated on the children's and her behalf by the woman. On the whole, respondents' husbands were or had been willing to stay home with the children or collect them from school and so on, if he was available when the doctor was in her

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6 One doctor had eight children, two had five children, five had four children, six had three children, nine had two children, and three had one child.

Table 10.1 **Doctors' ages, numbers of children and children's ages**

Doctor	Age	No of children	Ages of children
1	52	5	all adult
2	49	4	16→ 2
3	67	none	n/a
4	34	1	3
5	37	4	14→7
6	50	3	26→15
7	31	1	15 months
8	53	3	23, 20, 18
9	38	2	10, 5
10	40	2	14, 9
11	44	2	18, 15
12	47	2	21, 19
13	44	none	n/a
14	45	2 stepchildren	21, 19
15	41	2	7, 4
16	59	3	all adult
17	68	1	all adult
18	46	4	2 adult, 21 & 19
19	44	2	13, 10
20	29	none	n/a
21	48	8	7 adult, +12
22	52	3	all adult
23	49	2	all adult
24	56	3	all adult
25	32	2	$2\frac{1}{2}$, 4 months
26	68	4	all adult
27	49	3	20, 18, 14
28	54	5	3 adult + twins 17
29	65	4	all adult

surgery or called out, but this was something that had to be negotiated and arranged by the woman. This aspect of negotiating childcare was discussed by a number of the doctors in the study, and was best illustrated in the initial stages of the project by one of the doctors in the 'pilot' interviews (see chapter 4):

> Q Where would you say the ultimate responsibility lies?
>
> A I would feel that we **share** the ultimate responsibility, except I take the responsibility for sorting out where the kids are. I do take that ... the buck stops with me as to where the children are and who's looking after them .... It's my job to sort it out you know. When the people that are doing it go on holiday I have to fiddle around and work out what to do. Even if he does it I have to **negotiate** with him. But yes, **I do take the responsibility** (emphasis added) (no P2)

So, it can be seen that the process of negotiation is a complicated one. This particular woman explained at length the complicated arrangements she had for looking after her children, not only for each day of the week, but also for different times of the day, arrangements which involved several different people. What is apparent, however, from this particular case is that the initial attempt to talk about sharing of responsibility becomes, within the space of a few lines, "I do take the responsibility".

The heavy burden of single-handed practice would appear to be almost irreconcilable with the care of very young children, given the above discussion on 'planning', 'egalitarian overlay' and 'negotiation' that typifies the home lives of the GPs in this study. In effect, few (only six) of the GPs were working single-handedly when they had young children. Of these, two had had some form of role reversal in the home as described earlier in the chapter (nos 4 and 16). The others had had a variety of different working

arrangements (these are considered below) but most did not work as single-handed GPs until their children were at school. They had not taken on the ultimate professional commitment of single-handed practice while they felt they had to have full domestic involvement.

The 'problem' of childcare does not end, of course, when children are at school. Several studies have shown the intensification of the problem of childcare for professional women during school holidays. For example, a survey of women dentists "exposed the problems of arranging cover for the school holiday period and the dependence on paid help" (Fox and Seward, 1980:91). This was no less true for the women GPs in this study. While some form of paid help was used by many of the women, this was usually not for care of children but for help with other household tasks, particularly cleaning. For childcare, there was much more dependence on grandparents, especially grandmothers, some of whom lived with the family. Such an arrangement solved very many of the aspects of childcare which could involve the need for negotiating time with other people. The grandmother could most often be available for taking and collecting children from school, for school holidays, for children's illnesses, for on-call cover, and evening surgery cover, and other baby sitting - all important and time-consuming aspects of the GP's responsibility for her children. Where grandparents were willing and able to help they were found to be an invaluable form of support and often more reliable and dependable than were husbands. However, where forms of family support were unavailable, or not dependable, it was more likely that the GP had not taken on her single-handed practice until a later stage in her children's lives, when they were less dependent. There were long and complicated explanations given by many of the GPs as to how arrangements were made and negotiated over

the care of their children. These problems are faced by most working mothers (Sharpe 1984), of course, but are exacerbated when the mother has a demanding professional career, with commitments to work often at unplanned times. Perhaps the most important contribution of this study to the present extensive body of literature on childcare and the professional mother is the way in which it shows how the demands of career and childcare are played off against each other when both require 24 hour cover which has to be 'planned' and 'negotiated' by the woman. The concept of 'negotiation' by the mother for childcare extends Lorber's (1984) thesis on the 'planning' of childcare and the 'egalitarian overlay' within the professional household; these are only possible through 'negotiation'.

10.4 Children and career

The effect that children may have on the development of a professional career has been discussed extensively in the literature. It is well known that women working in professions tend to put off marriage and child-bearing until somewhat later than non-professional women, until they have been able to establish their careers to some extent. Studies of different professions show that, for example, women lawyers (Spencer and Podmore, 1984), women managers (Marshall, 1984), women civil servants (Fogarty et al, 1981) and so on marry later and have children later. This is true also of women doctors (Elston, 1980; Lorber, 1984), and was true for a majority of the women GPs in this present study. It is apparent that the prospect of children affects the way they allow their careers to develop, in the early stages especially. Very few of the women GPs stopped work altogether when they had children, apart from the normal maternity leave period. However, the kind and amount of medical work they were doing was

affected by their having children. Some did work which they would not have chosen to do if they had not had the responsibility of child care. For example, as indicated in Chapter 6, they did work in family planning, community health, school medicals, baby clinics, and sessional work in general practice, all of which did not involve out-of-hours emergency calls or night work and could often be done on a part-time basis. Areas where it is generally possible to work part-time are those which are less central to career development. The lack (until very recently) of part-time training in general practice is mirrored in most other specialties. It would seem that part-time training in general practice on a much larger scale would help keep women in fulfilling medical practice rather than channelling them into those aspects of medicine which can often be pursued by those less qualified than themselves. The constraints and frustrations of such practice can be considerable - doctors working in some aspects of community medicine are not permitted to prescribe, for instance. Provision of part-time training in other specialties would allow women to feel less divided in their loyalties at times when they could be using their energies more constructively. The recent provision of part-time training in general practice has meant that women take less time off for maternity leave, thus keeping them vitally involved in medicine, and avoiding the problems which the Retainer Scheme was meant to overcome (and for the most part failed to do - (see chapter 3)).

Those women in this study who had made big compromises in career terms by working in community health for a time talked of frustration and boredom during those years. Despite (even before the recent training developments) general practice being more easily reconciled with having children than say, surgery (Elston 1977, 1980; Turner, 1979), it was still

viewed by some as requiring more commitment than they felt able to combine with a young family. One woman said that if she had not been married or had children:

> I'd have done general practice, I always wanted to do general practice. I would not have done the public health (no 23)

Another worked on a sessional basis in public health for 23 years:

> I was appointed to two sessions a week, well baby clinics, injection sessions for polio and diphtheria and all this sort of thing, and school medicals.
>
> .... And then in the meantime as well I'd got embroiled in family planning, and that used to be two and three sessions a week, mostly at night .... (no 28)

And another:

> .... they offered me antenatal clinics and maternity sessions clinical assistantship,[7] at the maternity unit, so I did that for a few years. (no 19)

Others who went into general practice at an earlier stage in their career had worked as assistants (perhaps part-time) on a sessional basis to avoid on-call responsibility, but had continued with this situation for considerably longer than they would have wanted to because of the strong domestic pull which they felt. A factor which makes working full-time, or following a career post, as a doctor difficult to reconcile with child care duties is that very often the woman sees this aspect of life as her duty. Coser and Rokoff (1971) have referred to this as the 'cultural mandate' which prescribes that the primary allegiance of women is to have a family and that men provide the family with economic support and social status.

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7 A clinical assistantship is a non-career hospital post.

Consequently, it is not always necessarily or entirely a case of an unwilling husband, or lack of opportunities for alternative child care arrangements, but rather the normative expectations that society imposes and the woman internalises through her view of 'motherhood' and what it means where child care is concerned. For example:

> I enjoy being with them and I wanted to organise trips and doing things just because I wanted to do it. (no 6)

And another

> I didn't want anybody ever to look after my children for me .... (no 16)

One aspect of expectations on women to look after their own children in combination with working is the idea that the children may suffer. It has certainly been suggested that the children of a doctor's family suffer in a qualitatively different way from the children of other professional families (Nelson 1981; Pereira Gray 1982). The so-called 'suffering' implied here concerns the health of the children in that it is suggested that doctors do not treat symptoms in their own children as seriously as those of their patients. In this research some GPs had talked about their fear of neglecting their children where their health was concerned, and how they found it difficult to judge illness in their own children - either over- or under-reacting to circumstances. However, 'suffering' was expressed more in terms of an emotional problem rather than a physical health one. One GP in particular felt that her daughter had suffered through her working. She felt that this was due to the difficulties she had experienced in arranging for her care:

> It's interesting that (it's) my daughter who I really think suffered most, because of me going back to work, she was rather pushed around from pillar to post, and I had great difficulty finding people to look after her .... I'd find a note pushed under the door on Monday morning saying I'm not coming again .... I thought she'd be scarred for life. (no 23)

Feelings of guilt such as those expressed above were not uncommon, and are in line with the research findings on women in other professions.

Children do not necessarily affect decisions about career in isolation from other factors. While marriage itself may be enough of an impetus for some women to lessen their sights in terms of their career, others were greatly influenced by their partner's attitude. So that while some said that marriage and children had not affected the development of their careers and the choices they had made, others clearly felt that these had been influential factors. Of course, for a few, general practice had been a compromise decision in that without husband or children they would not have gone into general practice. One particularly felt she had missed out, having gone quite a way in a hospital career before opting for general practice:

> I'd have specialised (in ophthalmology) long ago. Well I think if I didn't have children or if I married and had no children, I may have really gone to the top, I think I would have done .... been a consultant or something, I'm quite sure about that .... (no 5)

Another stated quite categorically that general practice had most definitely been her husband's choice for her rather than her own.

So, while most of the women had chosen to become GPs as a positive decision, the road to the decision was by no means straightforward.[8] There were those who had compromised by following non-career posts on a sessional basis (one for 23 years!) before becoming GPs as they had wanted to. Others had been sessional GPs for some time before taking on the responsibilities of partnership or single-handed general practice and a small minority had worked as GPs as a compromise between career, marriage and children and regretted the loss of a hospital career in medicine.[9] It is apparent, though, that it was rare for women GPs to be the leader in career terms in their families - they invariably made the compromises which seemed necessary, rather than their husbands.

10.5 'Failed marriages' and medical husbands

Twenty-six of the 29 doctors were or had at some stage of their lives been married or in a similar relationship. Of the 26, three were widows, two were divorced and living alone, one was separated and living alone, one was divorced and living with a new partner, five were married for a second time making nine 'failed' marriages in all. This is shown in Table 10.2.

The impact of the professional/domestic interaction on women GPs' lives is demonstrated by looking at the 'failed' marriages. The women concerned talked of their careers as having contributed to the failure of their

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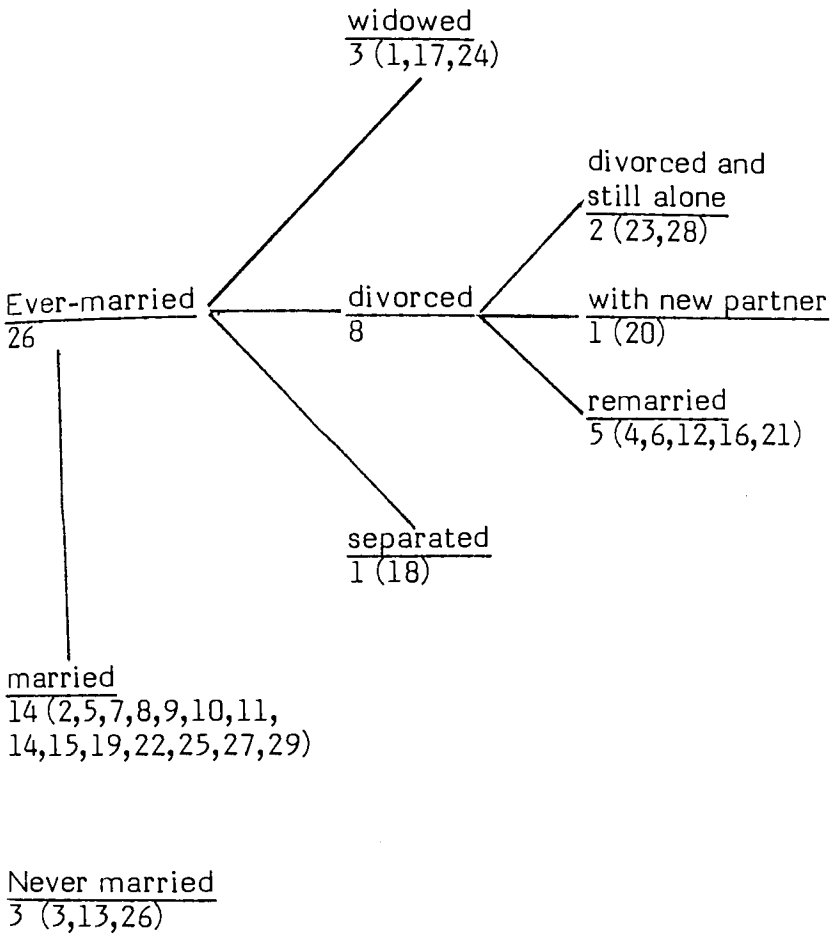
8 This was discussed further in Chapter 6.

9 In Chapter 11 it is shown how such regret had not been long lasting.

Table 10.2 **Doctors' marital status**
(Doctors shown in brackets)



marriages and subsequent divorces. They emphasised not only the lack of support or encouragement given to their careers, but also how this had an impact on the domestic situation. These were the women who dwelt on the lack of support in the home from partners and how the whole dichotomy of professional/domestic/partner antagonism and so on had led to the commonly-expressed feelings of guilt towards different aspects of their responsibilities. One woman, for instance, who said she had always done all the housework, and that this had always been her responsibility, clearly demonstrated a conflict between her professional and domestic lives when she said:

> .... whether that's why I got a divorce now, I don't know, because I haven't had time to sort of be perhaps as good a housewife as I now regret that I hadn't been .... (no 28)

This conflict had clearly contributed to the breakup of her marriage and left the woman with feelings of guilt and inadequacy at what she viewed as her failure.

Where this sort of effect was influential in marriage breakup, the women attempted to be especially careful the next time around. Five of those who had been divorced had remarried and for the most part this was a much more positive experience than the first time around. One did speak of the continued problems of acceptance of her professional role by her second husband, despite his being more supportive within the home than her first husband. She was unsure how this would develop, and quite what she would do about her practice:

> He would love me to pack up, in fact I'm hanging on by the skin of my teeth. (no 12)

Epstein (1971) has suggested that marriage to a husband in the same profession may reduce the difficulties faced by many professional women, because of the greater mutual understanding of the demands of eachother's professional work. Podmore and Spencer (1982) support Epstein's suggestion, but in their work on women lawyers also recognise the ways in which this can cause strain between a couple. Thirteen of the 26 doctors who had married had husbands who were doctors. Of the 13, three were married for a second time, the second husband not being medical. One divorced doctor who lived alone, had been previously married to a doctor

too. Five of the doctor marriages had failed (out of nine failed marriages overall). No remarriages were to doctors. Seven of the 13 doctor husbands were GPs, five of whom had at some stage been in general practice with their wives. Epstein's suggestion that there is a reduction of difficulties in marriages within the same profession is hardly supported by the examples of the doctors in this study. From the women's point of view it would seem that the lack of the partner's support within the home is resented even more when the professional pressures are (or should be) understood and experienced in parallel. One example (although perhaps an exaggerated one) of a wife and husband who practised together until their divorce is worth looking at, since it shows how the husband used the professional practice relationship with his wife in a similar way to the home relationship, to exploit her. While she took total responsibility for the home (with domestic help) this situation was extended into the practice. The fact that he often disappeared in the middle of running his surgeries leaving her to finish them off is perhaps unusual, but he also chose very selectively which patients and which sorts of cases he wanted to see, retaining control over the division of labour within the practice. But another important aspect of their practising together was that she was not equal to him in financial terms within the practice either. As she said:

> .... he kept me on a very small partnership because he said, when he retired it was much better for him to have a large pension to keep both of us, so my partnership was .... just the minimum you were allowed, ... I should have had 50:50 (no 21)

This partnership had broken up as well as the marriage and the woman GP questioned whether this marriage would have 'failed' if they had not practised together, the professional relationship having exacerbated the problems of the marital one.

This chapter has dealt with the domestic and home lives of the single-handed women GPs and interaction with their professional lives. Lack of support within the home has a considerable effect on the possibility of running a single-handed practice. The conventional division of labour within the home experienced by most of the women in the study threw a considerable burden upon them. However, control within the practice is fundamental in dealing with the interaction of professional and domestic lives. It is through the ultimate responsibility and authority which the women GPs had in their single-handed practices that they were able to cope and to have some control over the interaction of their two roles. By looking in the next chapter at some of the attitudes and aspirations of the women GPs it will be possible to clarify further the factors which have conditioned the choices, decisions and actions they have taken, and those which they plan to take in the future.

CHAPTER ELEVEN

THE ATTITUDES AND ASPIRATIONS OF SINGLE-HANDED WOMEN GPS

The professional and domestic lives of the women GPs have been explored in chapters six to ten, but there are certain other aspects of their experience which give further shape to the analysis of them as single-handed women GPs. It has been shown that the decisions, choices and actions which have occurred throughout their lives have been directed and channelled by a variety of factors, many of which are gender related. These have played some part in shaping their attitudes and the ambitions and aspirations they have for the future. An examination of the attitudes and aspirations of these GPs will also broaden an understanding of some of the actions they have taken and views expressed, shown in the analysis so far. In the interviews with the women GPs a number of areas were explored - on women in medicine and general practice, on the issue of 'wastage', on their satisfactions and disappointments, and the ambitions and aspirations they had for the future.[1]

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1 The women GPs were asked questions along the lines of "What do you consider to be the advantages and disadvantages for women in medicine?"; "What have been the main satisfactions and disappointments in your career so far?"; "What do you think about the question of wastage?"; and "What ambitions and aspirations do you have for the future?" The discussion which follows is based on their responses to such questions.

11.1 The 'advantages' and 'disadvantages' for women in medicine

This section examines the views of the women GPs on the 'advantages' for women practising as doctors, and the 'disadvantages' too. Such views reflect the pros and cons for women doctors and their patients. Strong views were expressed on these issues and several themes ran through the responses. Many of the responses mirrored stereotypical views of women in both career terms and in terms of their relationships with patients.

Looking first at medicine as a career for women, there was a clear feeling that general practice is a particularly good specialism for women to work in because of its flexibility in terms of hours, enabling women to accommodate their domestic responsibilities. As two doctors commented:

> ... one of the advantages is the flexibility which does enable you ... at every stage, to combine medicine and bringing up a family. (no 8)

> ... if you're ... more of a domestic woman you can certainly work part-time very easily in general practice, and with the flexibility of surgeries and hours and things like that it must be very easy to cope with if you want children, or just the extra time off. So I think it suits a lot of women from the point of view of the hours. (no 20)

This view assumes, of course, that women with children will make compromises in terms of their career for the benefit of their family. The advantages of general practice and its flexibility were made clear when careers in hospital medicine were discussed. Certain hospital specialties were closed to women with children, since it was assumed to be impossible to reconcile career and family. Surgery, for instance, was considered a wholly inappropriate specialism for a woman with child care responsibilities. Doctor 7 asked:

> ... can you be a part-time surgeon? ... it's difficult ... I mean if I was to be in my brother R's shoes who's pursuing a surgical career, there's just no way that as a woman you could survive if you were married and trying to ... combine home life and hospital life ... (no 7)

Another had learned this from her own experience:

> ... sometimes I think I miss general surgery, which I wanted to do, I really enjoyed when I was doing it ... when I started it I thought it would be possible and I'll be able to continue in general surgery, while later on I think with the house to run with general surgery, I couldn't have done it. (no 27)

These doctors confirmed the experiences of many women attempting to work in surgical specialties. In chapter 2 it was shown how women hospital doctors are concentrated in the non-surgical specialties and how they are even less likely to reach consultant levels in surgical specialties than others. In chapter 6 where the careers of the women GPs were traced, it was similarly possible to see how, as women they were excluded from certain career possibilities.

The bias against women in hospital medicine was frequently mentioned:

> I would have thought in the interviewing committees in certain hospital spheres there will be definite disadvantages to being a woman ... because I've got an uncle who's been sitting on interviewing committees and you ought to hear what he says about women in medicine, ... the only women in his year are all spinsters and totally dedicated to the cause, and I think that the system in hospitals ... you've really got to be totally dedicated. (no 7)

> ... every time I went for a house job I always felt ... that whenever there were three or four young men waiting there, I thought, oh what chance have I got? (no 5)

However, doctor 14 felt that the situation for women in hospital medicine used to be much worse than it is today. Not so many years ago women were so much less 'visible' within the profession and were clearly a minority group:

> There were disadvantages when I was starting out definitely, because we were very much a minority group ... and women weren't quite so accepted. I mean there were various surgeons and physicians in E.... who wouldn't have a female houseman, for instance. But I think the equality now, I think those disadvantages have definitely gone. (no 14)

She explained further an example from her own experience:

> I can always remember being asked when I got my job in A...., what were my marriage prospects, and fortunately I had the wit to say, if there were any I would not be here, because I don't think I'd have got the job ... because they just definitely look on you, ... you'll be here for a time, you'll get married, you'll go away and have a family, and that's training space lost. (no 14)

There is little doubt that the prospect of marriage and childcare responsibilities greatly influences the attitudes of more senior (male) medics - not only in hospital medicine - towards women and women doctors are affected by this throughout the years when they are of childbearing age. This view was voiced by doctor 25 in relation to general practice:

> ... if I wanted to be a full-time GP (in a group) it would have been a huge disadvantage being a woman and being of childbearing age. It's very difficult to get a place, to get anybody to take you on, because they think you're about to leave to have children. (no 25)

Additionally, she suggested that women doctors tend to have children at a comparatively late age because of the long hours involved in working as a

junior hospital doctor, which also make childcare arrangements very problematic.[2]

Another disadvantage, which follows from the point made above, concerns the question of 'dedication' or 'compromise' - terms used to interpret the same issue in different ways by the women GPs. Doctor 21, for example, believed that it is untrue for women to suggest they are not treated equally in hospital careers to men. She blamed women doctors for not being prepared to be as dedicated to their careers as men:

> I think it's very demanding to devote as much time to your career as a man has to, because a woman's career really is not all her life, or it shouldn't be. (no 21)

While this view was not supported by any of the other respondents, it raises the question of what is 'dedication'. The above interpretation of the term presupposes the male image of the career, i.e. that a person is dedicated to a career only if they give it 100 per cent of their attention, 100 per cent of the time (Theodore, 1971; Coser 1974). It is rare for anyone, man or woman, to be totally 'dedicated' in this sense of the word (Hochschild, 1975) since there are any number of distractions which can affect the path to the ultimate goal of a professional (in medicine, to reach the level of consultant). By this traditional interpretation of 'dedication' it is impossible for women to be dedicated to their career if they are married, especially if they have children. Moreover, 'dedication' is impossible while a woman is of childbearing age, since distraction is still a possibility.

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2 This is the case for all the traditional professions which entail a long period of training and dedicated career building.

Consequently, a woman can only be dedicated to a medical career if she is single, and past childbearing age. In career terms she is, of course, by this time 'too old' and has been overtaken on the career ladder by younger, 'dedicated' men, with no career distractions.

In reality women are often 'dedicated' to both their career and their other responsibilities (usually family), but commitment to both necessitates compromise in one or the other, or both. As has been shown there had been an element of compromise in both career and family by most of the women GPs interviewed. Compromise, however, implies a rational process of free choice, whereas women are directed and channelled in different directions in the making of such 'choices' and 'compromises'. Doctor 11 feels that the problem for women is that "your attention is divided" between work and the family, and this is what forces these compromises to be made. Of course, for most men such compromises are avoided, even if potentially they have the same responsibilities as women, because of the support they are able to get in the home which enables them to concentrate their full attention on their careers. In other words, it is support at home which enables them to fulfil the role of the dedicated, committed professional (Fowlkes, 1980).

The women GPs referred to another disadvantage for women in medicine; because, as doctor 5 put it "the image of a doctor is a man".[3]
This has implications for the way men and women doctors are treated. This question of "the image of the doctor" relates to how people react to

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3 See Delamont (1980) who refers to the problems women professionals have in being accepted as professionals by clients, subordinates and others.

doctors; it was generally agreed that patients "have probably got a bit more respect for a man doctor than they have for a woman" (no 16). This is because, in our society women are just not viewed or treated as equal to men. This can have the effect of patients taking advantage of women doctors:

> ... a lot of patients think they can take advantage of women a little easier than men ... I think the patients talk too much to women (doctors) (no 20)

It can affect the woman GP's authority as an employer:

> I think it's harder to control your staff when you're a woman, mainly because you make friends with them rather than just treat them as employees. (no 20)

This question of 'respect' has been discussed by Elston (1980), who has shown that only older women doctors are treated with the same respect as men, that is when they are more like men having passed childbearing age and become closer to the image of the male professional.

Although the women GPs felt that they were disadvantaged in their medical careers compared with men, they expressed an idea of ambivalence, particularly when they compared medicine with other professions. In effect Kelly's (1975) contention that medicine is often viewed as a more suitable career for a woman to pursue than other science-based ones such as pure science or engineering was supported. The flexibility of general practice for women has been discussed but other advantages were shown to exist (for women in medicine), although some of these are contradictory. Medicine, it was suggested, is an equal profession - women get paid the same as men, and there are financial advantages in

easily being able to support a whole family on a woman doctor's income (especially a woman GP's). As one woman said:

> I mean if anything happened to J... I know that financially I could survive and support any family that we might have. (no 7)

This view of the advantages of women in medicine has more to do with the advantages for the women actually working in the profession than it does with any advantages in the existence of women doctors from a patient's point of view. The ambivalence of the women GPs' views was brought out in another contradictory statement, where it was suggested that women doctors are respected as much as men doctors:

> The advantages are being in medicine as opposed to something else. You are respected as much as the men are in doing exactly the same job, I think, in most spheres although there's some exceptions to that, but most, particularly in general practice ... people don't think that your view will be any the less because you're female (no 25)

What is being suggested by doctor 25 is the idea that women are a disadvantaged group within a high status occupation. Overall, then, medicine is seen as an advantageous career for women to follow, but women in medicine as doctors are at a disadvantage and face many career difficulties because of both family responsibilities and sexist attitudes.

The women GPs felt that women doctors have a special role to play as regards patients. Doctor 17 said that "it shouldn't make any difference" to the patients whether the doctor is a woman or a man. While, she suggested, "it depends on the doctor, not on the sex", the overwhelming

view of the women GPs was different. The vast majority of them thought that women doctors had a special role in treating women patients for a number of reasons. It was suggested that women patients preferred to see a woman doctor, particularly if they have potentially embarrassing conditions such as gynaecological ones.[4] The lack of women GPs can have disastrous consequences for women patients, as one GP said:

> When I first came here, there'd never been a woman doctor in H..., or for miles around for that matter - yet they simply flocked, the women that'd had horrible things wrong with them for years and daren t go to a man doctor ... really huge fibroids, massive things and prolapses they'd had for donkey's years and wouldn't go because they were under men doctors. (no 16)

Respondents suggested that women patients also prefer women doctors for another reason - women GPs were perceived as "easier to talk to" than men. Doctor 27 felt that this was the case for both women and men patients:

> (For) many ladies it is an advantage, because they can't talk to male doctors very freely, and that is the advantage. Even for men. I think ladies have more patience to listen to people, and many times ... even men ... they want to tell all ... (their) problems, and quite a lot of male doctors I think have no patience to listen to them. (no 27)

This view, which was endorsed by several respondents supports the stereotypical view of women GPs as being more sympathetic.[5] This image

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4 This can happen in reverse of course, and there were a few cases cited where men patients had been reluctant to see a woman GP for some of their more embarrassing complaints.

5 This was the view put forward in the JRCGP's (1979) editorial (see chapter 2.

of the woman doctor was put over by doctor 18:

> I think there's a definite place for lady doctors ... in the sense that a lot of women ... feel that lady doctors are somewhat more sympathetic to their needs because being a woman they feel that they can understand them better, and appreciate ... what they're going through ... (no 18)

This stems from the idea that it is only possible to understand a problem if you have experienced it yourself - hence the view that, with gynaecologyical conditions and those relating to childbirth, women doctors are best suited to caring for such patients. Doctor 5 explained some of the complications which can occur:

> ... talking about women's diseases, things like premenstrual tension, and ... things like that, I think a man doesn't know anything about those things. I feel however much he may have read about them ... he hasn't experienced it ... even pregnancy, childbirth, breast feeding, and weaning and all the little things of childhood. They know all the high flown stuff but the little things, I m sure they miss out, unless they've been really bringing up the children themselves. So I feel a woman doctor is better equipped to advise people on those matters than a man doctor, because I have found very experienced men doctors who tell the mother not to give any milk ... to the baby if the baby has diarrhoea, if she's breast feeding the baby, but forget to ... tell her what to do to stop her breast from getting engorged, and here she is in pain the next day trying to get in touch with an emergency doctor, something like that ... and mind you they re very experienced doctors but they just forget to say this to a woman ... things like that make me wonder. (no 5)

If doctors need to experience a condition to understand it, particularly those relating to women and children; if they are viewed as more sympathetic, and more patient; if patients talk more freely to women,

particularly where emotional factors are concerned,[6] then these reductionist views should have implications for the structure of medicine overall, and of general practice itself. Certainly, within general practice it is recognised by the women GPs and elsewhere that the majority of consultations are by women for themselves and on behalf of their children (Graham, 1984). This could lead to the conclusion that the male-domination of general practice is completely misplaced. On the evidence of the opinions of the women GPs it would appear that many more women are needed in general practice.[7] It would perhaps be more appropriate, given the distribution of patients by gender, condition and preferences for a female or male doctor, for the present percentages of women and men doctors in general practice to be reversed, that is that the present 18 per cent of women GPs should more appropriately be men, leaving general practice female-dominated and thus better serving the needs of the community of patients.

These findings, however, are contrary to those discussed in chapter 2 where little evidence was found that women doctors have a more expressive role, or that patients prefer a woman doctor (Cartwright and Anderson, 1981).[8] However, the contradiction can be reconciled by reference to chapter 7, where it was shown that women GPs have less control within groups and partnerships than men. Possibly, the unequal number of women to men GPs gives the women an unbalanced view of the gender distribution and needs of

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6 These are all factors voiced by the women GPs.

7 This view is also voiced by Rivers (1985).

8 This is not the case for Asian communities where cultural norms dictate that women patients should always see a woman doctor. This point is examined in chapter 12.

their patients. With more consultations sought by women and a propensity for them to prefer a woman doctor, it is hardly surprising that the women GPs perceived themselves as seeing more women patients than they probably were.

This section has covered the women GPs' views on the advantages and disadvantages for women in medicine in respect of medicine as a career for women, and the question of their role vis-a-vis patients. The suggestion is that the women GPs' perceptions of their experiences are different from the so-called objective evidence of other studies.[9]

11.2 The question of 'wastage'

Many of the women interviewed commented on the alleged 'wastage' of women doctors. 'Wastage', (see chapter 2) refers to the notion that it is undesirable to waste scarce and expensive resources on training women who, ultimately, will give priority to domestic commitments (Elston 1977, 1980).[10] It is pertinent to discuss the women GPs' views on the issue of 'wastage' because it demonstrates an element of inconsistency in their ideas on the role of women in medicine. This will become clear below.

The views expressed on the issue of 'wastage' ranged over a wide spectrum, beginning with:

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9 See for example Martin and Goodwin (1987) who found that doctors' perceptions of women patients' consultation behaviour and preferences were not matched by patient consultation performance.

10 Elston shows that there is more or less equal 'wastage' from the NHS of men too, but for different reasons than women.

> I think it is a disgrace and disgusting ... It's better not to qualify (in the first place). (no 1)

At the other end of the scale is the suggestion that:

> it's perhaps wrong of people to criticise women that are wasting their education ... I think that's her right, her privilege, she can do what she wants. (no 7)

There were some constructive suggestions, for example:

> Wastage should be prevented ... there should be more creches, things like that attached to the hospitals ... (no 22)

Another of the women GPs questioned the structure of the medical profession:

> I don't think it should be that women have to give up, but it isn't made easy ... and although ... there's all discussion and meetings of the Women's Federation[11] ... it never seems to get any further. (no 28)

This woman went on to suggest that more help from husbands on the domestic front would contribute to the reduction of 'wastage':

> ... it so depends on the husband you marry ... If he wants you to have a career then I think it's really for him to help you ... I mean I don't know how we're going to persuade the men to be mothers, and that's really the basic answer ... (no 28)

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11 Doctor 28 is referring to the Medical Women's Federation.

Solutions to the problem of losing women were thus of two kinds - for support (e.g. creches) to be provided in hospitals and, on the domestic front, for husbands to become involved in childcare. However, for the most part respondents blamed women themselves for the problem of 'wastage'.[12] There was criticism of the increased recruitment of women as medical students. The suggestion was made a number of times that women should not constitute more than a third of medical school intakes, since women drop out of medicine more than men. As one woman put it:

> I mean it's harder for the women in the sense that ... it's then more competitive, but you get the ones who are more highly motivated, more bright or whatever ... (no 18)

Doctor 16 put her views forcefully, too:

> I think it's an awful shame for somebody to take a place or to push somebody else's nose out who **really** wanted to be a doctor and then soon after qualifying ... just two or three years afterwards give it up. (no 16)

The suggestion was even put forward that women should be treated differently from men at selection for medical school:

> ... they should sift the women much more keenly or get to the basis of why they want to do medicine more than the men, because after all a man needs a career, and that's basically .. why he's doing it ... But a woman doesn't really always want a career ... (no 21)

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12 17 of the 29 women GPs blamed women themselves for the problems of 'wastage'. However, these women did not reveal particularly radical views and it is a common response of women who have 'made it' to blame the victim.

One of the consequences of encouraging equal numbers of women and men in medical schools is the prospect of "far more wastage in the future" (no 4).

The women GPs thus did not appear very sympathetic to the position of women and this may well be related to the tendency of women who see themselves as having 'coped' successfully to be critical of those who had not.

The need for women to leave the profession for childcare was questioned. Doctor 10 felt that it was never necessary for a woman doctor to give up medicine because "nowadays you can always find somebody to look after your child".[13] And in addition, as doctor 13 recognised:

> Doctors can make enough money and they can afford to have a full time worker to come to their house ... you get a full-time nanny if you are willing to pay. (no 13)

Respondents also felt that, rather than giving up work altogether, women doctors should consider working part-time (ignoring the difficulties often involved in this). As well as fulfilling themselves as doctors they do not then lose touch with medicine. Examples were cited of how difficult it is to return to medicine after a long break from it, both in terms of being up-to-date with new developments, and also in terms of losing confidence in

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13 Spencer and Podmore (1984) show just how difficult domestic help and childcare is to obtain. This same issue was discussed in chapter 10.

themselves through being away from practising medicine. In this connection the Doctors' Retainer Scheme was not rated very highly by respondents (see chapter 3).

As can be seen, the responses to the question of wastage included both constructive suggestions for helping women in medicine, as well as more generally felt, rather negative attitudes which saw change in terms of individual adjustment by women. These negative attitudes indicate (as suggested above) an inconsistency in the views of some respondents. For instance, in the previous section respondents were shown as arguing for a definite role for women in medicine because of certain of their characteristics which made them in many ways more suited to the requirements of being a doctor than men. This led to the suggestion that the profession overall needs more women than men. Conversely, when discussing the issue of 'wastage' of women from the profession, it was proposed that limits should be imposed on the recruitment of women. Perhaps the reasons for the majority of the women GPs coming down so hard on women doctors who leave the profession is that they themselves have successfully overcome, admittedly in different ways and to different degrees, the problems of childcare which the 'wastage' women have found more difficult to solve.[14]

Some of the points discussed so far in this chapter are raised again in the next section where respondents' career satisfactions and disappointments are examined.

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14 See also Knudsen (1969) on this.

11.3 Satisfactions and disappointments in their careers

It was evident that while several of them had wanted to specialise in different areas of medicine early on in their careers (see chapter 6), the fact that they had had to alter their career paths had not been a lasting disappointment for them. Though some had at first been disappointed over the way they had been channelled away from their preferred specialism, there were no really lasting regrets. Any regrets were for the most part tempered by their positive feeling for general practice. One doctor talked most strongly of her regret at not specialising to become a consultant in obstetrics and gynaecology:

> I (regret it) ... very very much indeed ... Workwise I was more satisfied working in hospital ... and I never wanted to be a general practitioner ... but after I worked for a few months, then I changed my mind. (no 11)

But generally, disappointments over not specialising were less strongly phrased:

> ... sometimes I think I miss general surgery, which I wanted to do, I really enjoyed (it) when I was doing it ... (no 27)

However, she did not regret leaving that specialism any longer.

Other disappointments were expressed with regard to different aspects of general practice. There were some criticisms of patients and their use of the GP - some patients, for example, were said to be never grateful for what the doctor attempted to do for them. One doctor voiced this feeling vociferously:

> I mean some patients, no matter what you do with them, they moan and groan and then just complain, and then all sort of things happen. But not many. (no 13)

However, disappointments over patients were more concerned with occasions when treatment had been unsuccessful:

> Inevitably things don't always go right, and there are some very very grave unhappinesses when people don't get better and such like, and you can take it very very much to heart ... (no 26)

Disappointments such as these were seen as an inevitable feature of practising medicine and were more than matched by the enthusiasm the women GPs displayed for general practice. There was a deep sense of satisfaction with comments such as "extremely satisfying", "I love the job", "I get a lot of satisfaction out of general practice" and so on. These comments were accompanied by explanations of what was satisfying about general practice. For example, doctor 16 saw herself as the traditional GP, and this view of general practice gave it a generational continuity:

> I try to think of myself as a family doctor. I'm growing up with patients, I've stayed in one place for all these years, and I've grown up with them. I'm looking after women now who, I looked after their grandparents ... I've got patients having babies now, and I looked after ... their mothers and grandmothers when they were having them ... So you know the family. (no 16)

This view was reiterated by doctor 26, another 'ideal-type' traditional GP of long-standing:

> I have one very strong view in that I say you must stay in the same place, and your satisfaction comes from that. Now when I tell you that I've got lots and lots of families of four generations ... now do you understand why I like general practice?[15] (no 26)

Although many of the women GPs were too young and had been too short a time in general practice to be able to voice such opinions, most were aware of this aspect of 'continuity' which could be so satisfying. For instance:

> I think its quite satisfying seeing people grow up. I've only been here two years so ... the babies I've delivered two years ago are only just two, but it's nice to see them grow up and things like that. (no 20)

Doctor 25 another young doctor, found this an important aspect of general practice too:

> I'm beginning to enjoy and look forward to the fantastic sort of continuity of it in that the patients who you're looking after you're seeing ... through their whole lives ... well I find that very thrilling, it's fascinating to watch the children. I mean already I see babies that I ... saw born and they're now three or something. It's a bit like a continuous Archers serial to me, and I enjoy that aspect of it, I enjoy really watching other peoples' lives aspect of it. (no 25)

The idea of continuity was thus very important. It was particularly so in terms of choosing to be a single-handed GP where continuity is much more completely attained. This was discussed in some detail in chapter 7.

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15 Cartwright and Anderson (1981) suggest that this is a factor for patients too. Satisfaction with the care they received increased with the length of time they had been with their doctor.

Another aspect of general practice which the women GPs found satisfying is also related to the idea of 'continuity' in that it concerns the continuity of the treatment process. Here the satisfaction is in 'professional' rather than 'social' terms. What GPs found satisfying was making a diagnosis, treating it, and seeing patients get well:

> I suppose really the satisfactions are ... sitting in here, somebody comes in with a problem, and you understand the problem, or you make the diagnosis ... and you know the treatment. I mean there are very few pleasures as great as that - to be faced with a problem, identify the problem, and to find a solution ... (no 18)

> ... you have the satisfaction of following something all the way through and making a diagnosis before you send them off to hospital, I think that's very nice. (no 20)

Other more general comments on areas of satisfaction included "I'm happy that patients are happy" (no 10), "to be able to do something which you feel is a rewarding job" (no 28), "(to be able to help people) ... in very significant events in their lives" (no 8), "relieving the sufferings" (no 1) and so on. The enthusiasm for general practice itself was considerable, but practising single-handedly made general practice **completely** satisfying. As doctor 9 said of general practice:

> I don't think that there's anything that I would really rather do than what I'm doing ... (no 9)

And of single-handed practice itself:

> I very much like doing my own work on my own. (no 11)

The problems of working in group and partnership practices were discussed in chapter 7, where a comparison of group and single-handed practice brought out what the women GPs viewed as the positive attractions to working single-handed. Their perceptions of these positive attractions had been borne out in practice. But an examination of the future ambitions and aspirations of the women GPs brings forward further points for analysis.

11.4 Ambitions and aspirations for the future

The ambitions and aspirations that the women GPs had for the future were, of course, dependent to some extent on their ages. Inevitably, the older GPs who were nearing the end of their careers were more concerned with when and whether they would retire or carry on as single-handed GPs for as long as possible. Most of the women GPs saw retirement[16] as something they would eventually reach and do, although, for the most part, they had not planned this and did not know at what age they would do so. In fact, two doctors said they would never retire if it was possible for them to carry on working in the way they were. Doctor 24 was very clear about this:

> I will continue as long as my health holds, or I drop dead ... I will continue to practise unless it is that we have to retire. So far I don't think we have to retire. (no 24)

16 The present situation on retirement for GPs is discussed in chapter 3.

Those who envisaged retiring had some ideas about how they would go about this. Doctor 8, for example, wanted to build up her practice enough to warrant taking on a partner who she would be able to hand the practice over to, while doctor 26 wanted to make arrangements for her son to take the practice over from her.[17] Others did not have specific plans regarding the practice arrangements they would make on retirement.

The younger GPs obviously had few plans or ideas regarding retirement and were unable to see that far ahead. There was substantial agreement over the satisfaction of practising single-handed and in continuing to do so. For example:

> I suppose just to go on working and enjoy it and be quite happy (no 21)
>
> I would like to carry on working as I am (no 11)
>
> I'll just continue in general practice ... I'll work as long as I can. (no 27)

Others, however, talked about some of the difficulties of continuing single-handed general practice and had plans for getting over these difficulties. For instance, doctor 27 envisaged taking on a partner at some stage to cope with the growing size of the practice. Doctor 20, however, wanted to take on an assistant to cover afternoon surgeries, so that she could then build up her private work.[18] There were some who would like to have a colleague

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17 There are specific rules regarding handing over single-handed practices and it is for the FPC to choose a new GP to run the practice, not the retiring GP. It is for this reason that some single-handed GPs do take on a partner before retirement. This is discussed in chapter 3.

18 See the third case study in chapter 5 where doctor 20 had done this.

to discuss cases with. As doctor 18 suggests:

> ... it's really really nice to have somebody to discuss it with and so for that reason I miss not having somebody else in the practice ... that's a great disadvantage, but I don't think I could cope with the hassles ... of interpersonal relationships (no 18)

A few respondents were somewhat fearful of the future, because of the demanding nature of single-handed practice when the support of the deputising service was not available:

> ... two or three years ago I was really getting, absolutely, feeling old and ancient and dreading the phone going and dreading visits, hating calls I had at night, night calls especially. I mean when you're young you can cope, but when you get into your fifties it is a bit hard. (no 16)

One of the other demands of single-handed practice for this doctor had been the difficulty of attending post-graduate sessions which enable a GP to keep up-to-date and have contact with other doctors. Doctor 12, for example, planned to reduce her list size in order to be able to attend more sessions:

> ... I would like to run the practice down a bit ... I don't find the days long enough for what I want to do, especially as almost every day we have something going on at the postgraduate centre (no 12)

This was raised by doctor 4 too, who felt she would like to be able to go away on a course without having to think about her practice, but this would entail the expense of a locum out of her own pocket. This was a reason often given for finding it difficult to take holidays, though several of the women planned to take more holidays in the future.

In the interviews there was considerable discussion about the financial position of single-handed GPs versus those in group practice. The financial incentives given to doctors practising in groups, it was felt, discriminated against those working single-handed so that they were unable to afford many of the facilities which would make life much easier for them (and their patients). This affected the women in different ways since they had different financial priorities. Some did not use deputising services because of the expense; others did not use locums to enable them to attend courses or take holidays. Others dreaded the expense that their own illness would incur in terms of employing a locum. As one woman said "I live with the fear of being ill" (no 4). As doctor 12 explained:

> ... if there are three doctors together ... that's called a group, they get somewhere in the region of £1,000 each for being in a group. Now they may have only one surgery ... and so one could be doing one day and have four days off ... and certainly for holidays and weekend cover they don't have to have the emergency expenses ... because they can have every third day on, and the same with holidays, ... there are always two to cover the third one, it's no problem. If I want to be off then I've got to pay ... they don't have to pay anything extra for their work, I've got to pay more or else work double ... I totally disagree with the government giving group practices extra money and not giving single-handed people any money ... I think they should change that, they really should ... (no 12)

Despite such comments the women GPs remained overwhelmingly in favour of practising single-handed. The aspects of general practice which they enjoyed were for the most part enhanced when they practised alone, and by far outweighed the problems they had encountered. And the first-hand

experience that the vast majority of them had had of group practice[19] had served to strengthen their belief in continuing single-handed. Those who envisaged taking on an assistant at some time in the future felt that this would be possible because they would have control and authority in the practice and choice of who the person would be, rather than the way they had experienced partnerships in the past.

This chapter has explored some of the attitudes and aspirations of the single-handed women GPs. It helps toward an understanding of their professional careers and of the choices and decisions they have made. Discussions of the advantages and disadvantages for women in medicine, (whether they realised it or not) have clarified how the women GPs have been channelled in their careers. In addition it shows how reconciling professional and domestic lives have interacted with such choices. In effect, through talking of their views on women in medicine, they have given more information about themselves.

This chapter has also explored the satisfactions and disappointments of a career in medicine. For most of the women GPs the satisfactions derived from practising single-handed outweigh the disadvantages and the disappointments of past experiences and missed opportunities. Similar conclusions can be drawn from looking at how they view the future; the vast majority wish to continue practising as single-handed GPs.

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19 See discussion in chapter 7.

Disappointments and struggle are generally seen as a feature of the past, satisfaction as a feature of the present and future. The discussions in this chapter on the attitudes and aspirations of the women GPs have helped demonstrate also the importance to them of exercising some control and authority in their professional lives.

The particular experiences of one group of the women GPs, the Asian women, have not so far been considered as a separate entity. The following chapter, therefore, looks at the interaction of gender and ethnicity as factors in the lives of the Asian women GPs.

CHAPTER TWELVE

ETHNICITY

Of the 29 women interviewed, 13 were not of British origin, and 11 of these were South Asian (India, Pakistan and Sri Lanka).[1] This makes it important to look at how factors relating to the ethnic origins of doctors affects aspects of their medical practice and lives. In addition it adds a further explanatory dimension to the analyses discussed so far.

While the literature on the professions shows a growing awareness of the dimension of gender, it shows less awareness of ethnicity. Still less does the literature focus on those who are both i.e. black women. As Almquist and Wehrie-Einhorn have written:

> 'women employees' has generally meant white women, studies of black workers have focussed almost exclusively on black men .... (1978: 64).

However, this research would indicate the importance of an analysis of professional women from ethnic minority backgrounds. As will become evident, working as a **single-handed** GP may in part at least be the result of the double disadvantage of being both a woman and black in a 'white male' profession. The interaction of gender and ethnicity is complex and difficult to disentangle (though Liddle and Joshi (1987) have persuasively analysed influences of class and gender in respect of professional women in India). Almquist and Wehrie-Einhorn conclude that:

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1 The other two were doctor 17 from Eastern Europe and doctor 18, originally from China but educated and trained in the UK.

> .... gender appears to be more important than ethnicity in determining occupational distribution.(1978:81)

Epstein has suggested that black women do better than white women in the professions and attempts to explain the success of black professional women. As she says:

> To be Jewish, black, foreign born, or a woman have all been bases for exclusion from law, medicine, engineering, science, the supergrades of the civil service, architecture, banking and even journalism .... This is a report on a set of these deviants who possess at least two - and often more - statuses deemed to be "wrong". It attempts to analyze why they nevertheless were successful in the occupational world. (1973: 151)

She went on:

> .... relative to their male colleagues, black career women have done better than their white sisters; they constitute a larger proportion of the black professional community than women in the white professional world. (1973: 154)

She explained this as a result of black women being defined as 'superunique', making it possible for them to rise within the professional structures. In effect, being 'black' and being 'female' constitute a double negative status which cancel each other out. They experience less family-career conflict and feel more confident in their roles than do white women. Almquist and Wehrie-Einhorn have criticised Epstein for her small sample size and because of the distortion of including "numerous highly career oriented immigrants from the West Indies" (1978: 70). They suggest that one must be circumspect in talking of professions, since black women generally enter the 'female' professions - becoming nurses, teachers and

librarians and so on. A much smaller proportion of black women are in the male-dominated professions - doctors, dentists or lawyers.

In comparing the black professional women of Epstein's (1973) research and those in this study, it is apparent that the relationship between ethnicity, gender and the practice of medicine of the 11 Asian respondents is very different from that found by Epstein. Her thesis is based on analyses of women, who were largely of West Indian origin, while those in this study are of Asian origin. Consequently, her argument is based on family characteristics and a cultural background which is very different.

12.1 The Asian women GPs

None of the 11 Asian single-handed GPs was born in the UK and all received their medical training outside the UK in India, Sri Lanka and Pakistan. At the time of interview the ages of the 11 ranged between 37 and 56 years. Eight were married, two widowed and one was single, so that 10 of the 11 had been married at some stage. All of the ever-married had had children with children's ages at the time of the interviews ranging from two years up to adulthood - four had two children, three had three children, two had four children, and one had five. Five of the women were, or had been, married to doctors (three of whom were GPs). All the other partners were professionals (civil servant, solicitor, architect and engineer). Three of the women had formerly practised in partnerships with their husbands - one until she was widowed, one had split from her husband (only professionally, they were still living together!) and the third was still in practice with her husband although they were both registered as single-

handed GPs.[2]

Table 12.1 **Backgrounds of the Asian GPs**

Doctor	Country of origin	Age	Marital status	Partner's profession	No of children and ages
1	India	52	Widow	Doctor-GP	5 (all adult)
2	India	49	Married	Engineer	4 (16→2)
5	Sri Lanka	37	Married	Solicitor	4 (14→7)
10	India	40	Married	Doctor-GP	2 (14, 9)
11	India	44	Married	Government service	2 (18, 15)
13	Pakistan	44	Single	n/a	none
15	India	41	Married	not given	2 (7, 4)
19	India	44	Married	Doctor-GP	2 (13, 10)
22	India	52	Married	Architect	3 (adult)
24	India	56	Widow	Doctor	3 (adult)
27	India	49	Married	Doctor - anaesthetist	3 (20, 18, 14)

The practice list sizes of the Asian women GPs ranged from 1,000 to 3,000 patients - five had under 2,000 patients and six had between two and three thousand.[3] All but one made use of the deputising services, four for all on-call, six used them irregularly covering some on-call themselves, of whom

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2 This had occurred because when she had decided to join her husband in practice his list size had been too small to carry another GP. Consequently, she had applied to the FPC to start another single-handed practice from the same premises, which had been accepted. They had continued to be registered as single-handed GPs although in practice they worked together.

3 In the study overall, list sizes were between 1,000 and 3,200 patients.

two used the deputising services in combination with rotas with GPs from other practices. Three had their surgeries attached to their homes. None of the married women had any role reversal arrangement with their partners. For the most part the domestic scene was their own responsibility - although some did have, or had had in the past, the support of parents (mothers or mothers-in-law) in child, home and husband care. Five had some family connections in medicine which had influenced their decisions to become doctors - uncles, aunts, cousins and so on - although only one had a parent who had been a doctor. The other seven said that there were no family connections with medicine at all, until they had taken it up (see Chapter 6).

Table 12.2 **Practice list sizes, location of practice premises and out-of-hours cover arrangements**

Doctor	List Size	Practice location	Out-of-hours cover arrangements
1	1,000	Attached to home	Rota - sometimes
2	3,000	Converted house	Uses deputising service - sometimes
5	1,000	Converted house	Uses deputising service - sometimes
10	1,050	Attached to home	Uses deputising service - sometimes
11	2,500	In Health Centre	Uses deputising service - always
13	2,550	Converted house	Uses deputising service - always
15	1,200	Lock-up shop	Uses deputising service - always
19	2,200	Attached to home	Uses deputising service - sometimes
22	1,600	Converted house	Uses deputising service - sometimes
24	2,200	In Health Centre	Uses deputising service - sometimes
27	2,400	Lock-up shop	Uses deputising service - always

All these background aspects of training, career, practice organisation and domestic arrangements will now be looked at in more depth. The experiences of the sample of 11 Asian women doctors will be used as a basis for comparison with the other single-handed GPs in the study.

12.2 Career choice, training and career-patterns

As has been indicated none of the 11 Asian women came to Britain until after their medical training, some having worked as doctors for a number of years before leaving their home country, some having gained post-graduate qualifications and having reached quite senior positions. There were two interlinked reasons for coming to the UK - to follow their husbands and to take advantage of better post-graduate training opportunities. Some had been in Britain for many years at the time of interview.

If one looks at the reasons given for going into medicine it will be possible to gain some comparison with those of the British-born GPs. As will be seen, the differing image of medicine as a career for women in India means that girls are encouraged to take it up to fulfil a particular sex-typed role within medicine. Bhargava (1983), as indicated in chapter 2, identified a distinction between sex-stereotyping and sex-congruency in India. Sex-congruency is explained as the perceived compatibility between sex-role expectations and the demands of a specialty, while obstetrics and gynaecology in India demand women doctors because of women's supposed modesty and the expectations of their husbands and fathers that they consult a woman doctor - sex-stereotyping. There is, therefore, a particular role and demand for women doctors to work in women's specialties, and women are recruited to medicine with this work in view.

As already mentioned earlier, five had had family connections of some sort with medicine which had been a contributory factor to their going into medicine, although only one had the very close influence of a parent who was a doctor and had therefore lived in a medical household. One must look to other reasons for being attracted to a medical career. The reasons given for going into medicine and the specialisms pursued in the early years of practice before becoming GPs in Britain clearly substantiate Bhargava's (1983) work on sex-congruency. Seven of the 11 had "always wanted to be a doctor" from childhood. Other comments were "to relieve suffering", "I was good at science", "I liked nursing", "interested in people" and so on. Two of them made particularly illuminating remarks in relation to the analysis which follows:

> I think it's a good line for ladies (no 10)

> .... at the same time that I was training there were about 14 of us first cousins training to be in the medical profession, chose medicine as a career. Generally it was the men that went into business and the women had to decide a career, and it just happened that at that particular time .... most of the girls decided that they wanted to go into medicine .... (no 19)

In India,[4] then, medicine (and particular branches of it) is viewed as an appropriate profession for women to follow. Liddle and Joshi (1987) point out that the lack of medical care for women in India earlier this century meant that medical training for women was imperative. They quote a woman doctor who in 1929 wrote about "her suffering sisters and their

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4 In the rest of this chapter 'India' or 'Asian'will be used to refer to Pakistan and Sri Lanka, since nine of the 11 Asian doctors were from India, with one each from Pakistan and Sri Lanka.

children .... who would suffer silently even to death rather than be examined by men" (1987: 210). But, it was important too that women's work as professionals (doctors) did not break orthodox/traditional ideas about women's role in society:

> Medicine and education became acceptable professions for women precisely because they could be undertaken whilst maintaining sex segregation (though not, of course, seclusion) and minimizing contact with men. (Liddle and Joshi, 1987: 216).

Of all the professions in India women are most likely to be found in medicine (21 per cent in 1973). However, gender-based segregation does occur (as in all professions, not only in India) with most women doctors specialising in gynaecology, obstetrics, and paediatrics (Liddle and Joshi, 1987: 219-20). These findings are confirmed amongst the sample of Asian women in this study. When looking at the main specialism within which these doctors had worked before becoming single-handed GPs, seven of the 11 had specialised in obstetrics and gynaecology, while another three had specialised in paediatrics. Since, however, most had come to Britain to pursue post-graduate training with the intention of returning home on completion of their training, a change from the traditionally acceptable specialisms would have been unlikely, had they returned home.

Experiences of undergraduate medical training in their home countries were varied. One (no 10) had trained in a 'women's only' college, while others had been at mixed medical colleges with between 10 and 50 per cent women on the courses. Most respondents had no real problems to relate about their period of training. The doctor who had trained at a women's college had gained most of her experience on women patients:

Q So the patients were all women as well were they?

A Patients were all women as well, yes.

Q So you didn't really get much experience of treating men at that stage?

A No, ... we used to have sessions or clinics (at the men's college) as well, for the diseases ... which we really don't see there, you know, men's diseases which we don't see in the Lady Harding (College), we used to go there (the men's college), you know, like 9-12 for a three hour session or something like that, ... but we didn't have that much experience as we had with the ladies, you know, of course (no 10).

But others, having attended mixed medical colleges had been able to have more varied experience during their training:

> Some (male patients) would not let us examine them unless we have a male student with us .... (no 24)

> I was a bit naive about life, I mean I was brought up in a convent, terribly sheltered and I mean I had no clue about a man patient except I must be honest .... until my second clinical year I got away without examining a male patient. And .... it was hard manipulation work, but I managed to do that and then I thought to myself, crikey, that's ridiculous, you know .... (no 15)

The women did not mention academic problems or other difficulties with fellow students or staff. There was the suggestion that when the women got into medical school they were treated well, since they were treated politely as 'ladies'. Perhaps they received better treatment than would be the case in the UK. This is an area which would need much more careful investigation in order to be able to say anything conclusive. None of the women had experienced any form of formal career advice about specialisms to follow. This may well be related again to cultural norms about sex-

segregation, since it may well have been assumed that women would **know** which direction they were expected to take. Since many of them had started medicine with a particular direction in view, they had not felt that they had been forced into a specialty which they had not wanted to follow.

It is apparent that the women were channelled into certain specialties (obstetrics and gynaecology, and paediatrics) in much the same way as they are channelled in the UK, but that cultural norms and expectations dictate that some of the channelling will be into different specialties. While women in India are channelled into obstetrics and gynaecology and paediatrics, in Britain obstetrics and gynaecology are very much surgical high status, male-dominated specialties[5] and it is only in general practice that obstetrics and gynaecology are the province of women, where these activities have lost their status.[6] The careers of women doctors in India and other Asian countries are circumscribed and dominated by those with the most power, i.e. men, both within and outside the medical community. It is male-inspired tradition which dictates what women doctors do. This makes for a rude awakening when they come to Britain and find themselves in the 'wrong' specialism.

After qualification as doctors, the women's experiences differed according to which stage in their careers they had reached when they had come to Britain. While seven had come for post-graduate training, some had (as suggested earlier) primarily followed their husbands. However, they had

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5 See Scully and Bart (1973) where it is shown how men hold control over medical knowledge in this specialty.

6 See discussion in Chapter 7.

come at different career stages, two having arrived immediately post-qualification, others after practising only a short time, whilst others had a number of years in practice. One, for example, had owned her own nursing home and come to the UK 10 years after qualification. Most (six), though, had three or four years working experience before coming to the UK, three having already taken a further qualification (one, for example, had done her MD).

Coming to Britain for further training was encouraged within the medical profession, since they could gain experience not available at home. For the most part the women doctors gave no indication that they found training a particular problem. Problems started when looking for jobs. Many of the qualifications and experience gained abroad did not count towards registration in the UK. There were several examples given where the women's training and post-qualification house jobs had to be repeated before registration was counted. In any case, they found it difficult to find employment, except for locum work. In addition, since many had specialised in obstetrics and gynaecology, they found that they had little chance of progressing far - certainly not to consultant status - in that specialism. One respondent said:

> They really don't give you .... consultant job here after registrar job, you either become GP or you just keep on doing some locum .... I have seen people here who have done FRCS, ultimately they are GP .... So even though you do MRCOG or MRCP from here, you can get consultant job in .... psychiatry or geriatric or some (area) where no-one else wants to go, but they won't give you so it's a waste of time. They won't give you (if) you are a foreigner .... (no 10)

> Then I thought that I'm not going to get a consultant post in hospital .... Because one thing is that we are not a graduate from this country .... no matter what qualification you have you cannot be a consultant in the branch that I want, that was

> obs and gynae, I haven't seen any Asian or any foreigner become a consultant. (no 13)

Others had difficulties too:

> I had to do a house job before full registration. It was difficult to get at that time (registration). (no 2).
>
> They wouldn't accept my DCH experience towards medicine, or surgery, but my obstetrics and gynae they accepted, so they told me if I did six months housemanship .... then I will get my full registration (no 22).
>
> I had to start right from the beginning .... I had to start from SHO, that means staying in the hospital and you know with children it was difficult. (no 27)

There were thus several examples of women who had experienced a backward step when coming to the UK (having to complete again certain parts of their training and experience). Others felt that they would be unable to progress far (to consultant level) in their specialisms because they held overseas qualifications (whether this situation is true is not relevant, but rather the fact that they **felt** it to be relevant). Added to this was the fact that as women (and Asian women at that) they were trying to make their way in male-dominated specialisms in which many British-born (white) women have difficulty progressing.

12.3 General Practice

All of the Indian women at some stage decided to go into general practice. The reasons were various and inter-related. Some decided on general practice because of their lack of success in progressing in hospital medicine in their chosen specialisms (particularly obstetrics and

gynaecology); others, with family responsibilities, were unsettled by moving frequently in order to obtain hospital jobs. Others opted for general practice because of having to repeat some aspects of their training and experience in order to gain registration - this may have meant sleeping at the hospital. Some had husbands who had decided on general practice, and therefore it was convenient to practise together; some developed a positive desire to be a GP. General practice was often seen as a positive alternative to hospital medicine and, particularly for obstetrics and gynaecology specialists, it represented a way of specialising to some extent in the medicine which they knew. For most,[7] the choice of general practice was not seen as a negative but a positive one, although there were those who became GPs partly in order that they could practise **some** sort of medicine.[8] It was not their first choice of career but, given their domestic and family responsibilities in addition to the other difficulties they faced it was the only one possible. The constraints of family and domestic life on hospital careers were formidable:

> .... My job in hospital, even though I enjoyed very much the job itself, but it was a very strenuous job to work day and night when you're on duty, and I found it very difficult to look after the children, sometimes I have to leave them with nurses and so on, and I found life was extremely difficult for me, so we decided we would try in general practice job. (no 11)

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7 Only two of the Asian women had felt strongly negative about becoming GPs.

8 Smith (1980) showed that doctors who qualified overseas (among whom Asians predominated) were more likely than doctors who qualified in Britain to have become general practitioners against their inclination.

Another woman spoke of the disturbance to her children of being uprooted from schools every time she had to move hospital jobs:

> .... then I got into general practice, because of the children really, because I didn't want them moving around, just when they were getting into schools and getting into classes and it's difficult to move them from place to place. I thought the best thing would be to stay where I was and there was an offer in a general practice close by and I took it up but .... we didn't get on well. It was a terrible practice I got into (no 5)

The difficulty of getting into hospital medicine and getting on when in it was the reason why some women turned to general practice. Doctor 13, quoted above, could not get a consultant post in obstetrics and gynaecology because she was an Asian. Consequently she decided on general practice as an alternative option. And another:

> Q Why did you decide to go into GP work?
>
> A It just happened .... I was finding it difficult at the time .... after finishing one house job I applied here and there .... so this came up. (no 2)

> I didn't want to become GP because you see altogether I worked, ... nearly total I did 10 or 20 years work .... in obs gynae, so I didn't really want to give up, but I was forced to give up, because there was no alternative. I said to my husband let's go home, when I left hospital, and he was a bit reluctant that "look, now I started here, you want me to go home, and then we start all over again". So I said all right, I'll give up my job and become a general practitioner. So I became a general practitioner. (no 10)

Some women were strongly attracted to general practice:

> I wanted to be a GP .... I mean I knew what I wanted to do, and I wanted to do all the jobs, so that (when) I went into practice, I'd have done them. (no 15)

Decisions to go into general practice then were made for a variety of reasons. When comparing the Asian doctors with the rest of the women interviewed it is evident that the former had had more experience than their British counterparts and were more highly qualified at the stage when they became GPs. This was because nearly all of them had made the decision to become GPs at a later stage in their careers, having attempted to pursue a specialism at a higher level. Also, many more of the British (white) GPs had consciously chosen to be GPs at the beginning of their careers and had consequently not pursued postgraduate qualifications to the same level as the Asian women GPs.

Decisions to practise single-handedly were based on a number of factors (see Chapter 7) but past experiences of general practice contributed to these decisions. If one looks at the 11 Asian women doctors it is possible to see at work all the factors discussed in chapter 7 - financial grievances, personal relationships, continuity, independence and, the interacting fifth dimension, gender. For these women there was, though, a further factor contributing to the decision to practise single-handedly - that of ethnicity. This factor interacts with the five mentioned above, and in so doing identification of the 'double disadvantage' experienced by black women in Epstein's (1973) work is clearly seen. However, in looking at such examples from amongst this sample of Asian women, it is far from clear as to which of the 'interacting' variables - gender or ethnicity - is the most prominent in any particular case. The sorts of cases where 'ethnicity' shows its influence tend to be where an interpretation of the incident or 'sense' of an incident related could equally be offered in terms of gender.[9]

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9 Examples of such incidents are examined in the next section.

Did these women make their decisions to work single-handedly because they were **women,** because they were **black,** or because they were **black women**? And which is the strongest force at play? Almquist and Wehrie-Einhorn concluded that ".... gender appears to be more important than ethnicity in determining occupational distribution" (1978: 81), but Epstein (1973) has indicated the importance that being black has had on the lives of the women in her study. The complex interaction between 'gender' and 'ethnicity' will now be examined.

12.4 The interaction of gender and ethnicity

One doctor said that as a GP she had experienced little of the discrimination she had found in hospital practice:

> I'm the only Asian in this village, and they are all English and Britons, and .... all my patients are English. Only one couple is Asian .... so you can imagine, how much colour bar is there? .... Of course .... in the hospitals there was a high racial discrimination, even if you have very good qualifications, much more than the other one, if he is English, he will get the job, not you. (no 1)

It is apparent in this example that the doctor is confusing, in her comparison, the reaction of patients in general practice with the problems of getting a job in hospitals. However, another woman in identifying the problems of finding a single-handed practice (it took her three years) felt that this was related to her gender rather than her ethnicity, although this, of course, was never made explicit to her.

Another identified problems with the senior partners in her general practice before she practised single-handed, which she also linked with gender rather than ethnicity. However, she felt that in getting her single-handed practice both aspects had been problematic:

> I am a woman, and they don't want women doctors, that is if you are a foreigner .... (no 13)

Doctor 24 felt that her problems in managing to get her own practice were 'definitely' related to the fact that she was Asian, rather than that she was a woman. Another (no 5) had had a poor relationship with her senior partner in general practice, who put many obstacles in the way when she tried to form her own single-handed practice. Here, though, the emphasis seems to have been on the fact that she was a woman. However, she did feel that being Asian had been a factor in the past in trying to get jobs, especially being an Asian woman.

In terms of patients, several doctors observed that their Asian patients in the community were mainly women - because of the sex-segregation mentioned earlier:

> Majority want to see a woman doctor .... Yes, they do. Only there is no Asian males, they send their children and wives to me, but for themselves they feel bit embarrassed. I think being because of our culture, and they prefer a male doctor. (no 13)

Another woman felt that being Asian had attracted some of the Asian population to her practice:

> .... Quite a lot of Asian population, quite a lot of Pakistanis .... unfortunately I don't know their language, this is a handicap for me. But a lot of them are joining my panel because I am a lady and I am an Asian I suppose, and they expect me to speak the language, but they are disappointed, but still the Pakistani men are happy to have their females treated by me rather than taking them to a male doctor, even though I don't know the language .... I think it helps them .... there is some sort of rapport .... (no 5)

Doctor 22, who had a large community of Asian patients, talked about this in some detail, and particularly the importance of language:

> I try as much as possible to speak with them in their own languages. I speak about five, you see. (no 22)

This was important too because of the large number of Asian women who did not speak English and had little understanding of British culture, who were amongst her patients. She continued:

> It makes all the difference you see .... I realise myself how homesick I used to be. I used to dream of Indian food, you know. For three months I didn't know there was an Indian shop in this country, and every night I would be dreaming of this Indian food.....
>
> ..... a lot of patients come along and a lot of them got on to my list, you see. They didn't even know how to make beds, how to keep the houses warm, because you see in our country, it's a warm country, we leave the windows open, we leave the doors open, you see, shutting a door is a very rude thing. And here you have to learn new things .... Culture as well, bed clothes again, you know, they're always folded and put away, and then they're spread onto the bed .... many a time I've been to patients' houses and shown them how to make the beds .... (no 22)

She found the dual standards applying in British society rather confusing. Speaking of the tax laws, she said

> I mean in our country .... if I earn a man's wage, I am treated as a man and that would be that with it you see, but here it's a very fantastic world. You get two standards for everything .... (no 22)

Doctor 27's problem in getting parity in the practice in which she was a partner were related to gender. In fact, she felt that she tolerated the unequal situation for longer than she should because:

> I have found it's very difficult to get a partnership for ladies. I think it's very difficult for men to accept you as an equal partner. (no 27)

To summarise, very few of the women had found their ethnicity to be a problem in general practice. In many ways to be Asian was a positive benefit to their particular practices. Several doctors talked of problems in relation to getting jobs in hospitals, but gender seems to have been the more prominent discriminatory feature of their experience. However, several did talk about how practising in Asian communities affected the composition of their practices. Though many of the GPs in the study as a whole talked of encouraging whole familes to attend the same practice, it was amongst those practising in the Asian communities that families were more likely to be split between different GPs. This occurred because of the attraction which Asian women GPs held for many of the women patients from the Asian community, but few of the men.

There is thus an interaction between gender and ethnicity in terms of professional career and in terms of the patient population of Asian women doctors. However, the evidence from these interviews suggested that gender has more effect on them than does ethnicity. The interaction of the two factors, though, means that they are doubly-disadvantaged as a group.

12.5 Out-of-hours cover and the domestic sphere

These matters have been discussed in Chapters 9 and 10, where it was shown how the organisation of out-of-hours cover, and its link between professional and domestic lives, is crucially related to gender. This was no less true of the Asian doctors in the study. They were loath to go on night visits; they felt vulnerable as women when out; they took on a large amount of domestic responsibility so that they used the deputising services extensively and did not like having to rely on husbands and family to take messages and to deal with their patients. However, here too there was some interaction between gender and ethnicity in terms of the organisation of both out-of-hours cover and its link between professional and domestic life. This interaction will now be examined in more detail.

All 11 doctors made some use of the deputising services; most did so quite extensively although two were also in a rota with other GPs for some of the out-of-hours cover. This allowed for the least disruption to husbands/partners and family life. As one doctor said:

> In fact (being on call) didn't bother me at all because you know I can go to sleep any time, but it bothered my husband, it used to keep him awake. (no 27)

Disruption to the family was still unavoidable to some extent, since the deputising service does not cover at all times:

> .... occasionally .... suddenly you get a call at about 7.10 in the morning when the deputising is not working, and well I'll have to say I'm leaving and leave everything as it is and go out for the visit. I have done that. I've done that a few times since we started on my own, makes it a bit difficult for everybody but everybody accepts it. (no 5)

In Chapter 9 the vulnerability of women doctors when covering out-of-hours calls was discussed. The two women in the study who had been physically attacked were both Asian. Possibily the combination of being women and Asian made them more vulnerable than non-ethnic women, but there is no conclusive evidence on which to base such a suggestion.

In looking at the link between professional and domestic lives, it is evident from Chapters 9 and 10 that the women GPs for the most part took on the major responsibility for the home, particularly in terms of planning. It is also clear that support in their professional lives was essential for survival. For the Asian women good support from the deputising service was very necessary. This is not at all surprising since of those who received little support from husbands at home, a large number were Asian doctors. There were several examples of a total lack of domestic support/help from husbands from amongst the Asian women:

> Well, it is you know only ladies work, my husband doesn't do any domestic work as such, although sometimes he does help me nowadays, I suppose if I am busy or stuck or something like that, but mostly it is my responsibility to finish my housework .... but at home you see we have joint family, so they (men) never really get a chance to do it, mostly ladies do all the work. (no 10)

Most of the domestic support which is forthcoming in the household comes from other women in the extended family and several had, or had in the past, the help of grandmothers, or mothers or mothers-in-law, who lived with them and helped with work in the home and child care. This was the sort of assistance which they traditionally expected, rather than the assistance of their husbands. There were those who had had to adapt to a more 'sharing' sort of arrangement because family support was not available and because, in living in Britain for many years, they had adopted some aspects of British life. It was evident that these women mostly accepted the 'double burden' of responsibility for home and professional lives, despite mostly being members of 'dual career' families (Rapoport and Rapoport, 1971).[10] Because of the strong influence of the traditional family organisation, Indian women have a greater burden to bear as professional women when compared to their British counterparts. In addition, total responsibility for their practices and professional lives (in which there had been some influence in terms of their ethnicity in their choice to practise alone) all conspired together to make them a 'doubly disadvantaged' group.

12.6 Conclusion: is ethnicity important?

The evidence from the interviews with the 11 Asian women doctors raises considerations about the influence of ethnicity on single-handed women

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10 Leggon has suggested that for black professional women "marriage can be combined easier with business and law than with medicine" (1980: 199).

GPs. It tentatively suggests some ways in which their ethnicity may have shaped decisions, choices and actions; also ways in which the interaction of ethnicity with gender has had an effect on their lives.

There has been some influence on their careers, since as women there was little possibility of progressing to consultant level in obstetrics and gynaecology, though this has been their chosen specialism, a choice influenced by the norms of sex-segregation in India. This had influenced decisions to go into general practice, but general practice had also offered the opportunity to do some obstetrics and gynaecology - their chosen specialism. General practice, however, was for three of the 11 a choice made for them by husbands.

Having chosen general practice there were many examples given of difficult experiences in early partnership practice. The difficulties and problems discussed were mostly similar to those of the non-ethnic doctors, where difficulties which arose because of their gender were strongly influential on their decision to practise single-handedly. However, there was some evidence to suggest that ethnicity had **interacted** with gender, so that as Asian women doctors they had experienced greater problems. However, such evidence is inconclusive, and greatly dependent on some sort of racial awareness/consciousness amongst the doctors themselves. It could be that there was an unwillingness of some to accept this as an influence on their situation, while others were willing to place blame in that direction only too readily. The presence of a white interviewer could well have affected the sort of information and interpretation of experiences which the women divulged (see chapter 4).

The influence of tradition within the Asian household remained strong for many of the doctors. This meant that they had the 'double burden' of overall responsibility for both home and childcare, and for their practices, with for the most part a lack of any support from husbands (all of whom were Asian). Support within the home came from members of the family where they were available, although there was a change towards a more western style within some homes. However, these home arrangements strongly influenced a need for deputising services which were used extensively by most doctors.

The Asian women doctors tended to be more highly qualified, with training and experience to higher levels than the British GPs. This would be significant in any discussions of quality of general practitioners. None, however, were vocationally trained in general practice. Several of the doctors had practices serving large Asian communities, and this meant that many of their patients were women, since, once again, traditional norms dictated that Asian women should see a female doctor, while the men would see a male doctor. Traditional norms, then, were shaping the form and style of general practice for the Asian women doctors.

It is apparent that for these 11 Asian women doctors, ethnicity influenced career, practice and home life, but that this interacted with gender. On the evidence available it would seem that gender has been the stronger of these influences, but that separation of these factors is not always possible in explaining their experiences. In any case, the very number of Asian women doctors in the sample of single-handed women GPs (11 out of 29) surely speaks for itself in confirming the influence of ethnicity as an important factor in professional lives and in the way their careers have developed.

CHAPTER THIRTEEN

SUMMARY AND CONCLUSIONS

This final chapter examines the main issues raised in this thesis, summarises the findings and assesses their implications. Finally it recommends ways in which this research could be extended and enhanced in terms of areas of future study.

The aim of this research was to show where gender was a significant issue in the choices and decisions made in the lives of women professionals. Through in-depth, unstructured interviews with 29 single-handed women GPs an understanding was gained of the life of a woman professional who is under great pressure in her professional life because of her 24 hour ultimate sole responsibility for her practice and patients. By studying the women's own accounts of their lives it has been possible to illustrate the importance of the 'interface' between the domestic and the professional lives of women. The experiences and strategies of these women present a yardstick against which it will be possible to study those in apparently less pressurised professional circumstances.

The present state of knowledge on women in medicine and in general practice was reviewed briefly in chapter 2. It was evident both there and in later chapters that research has tended to be of the 'quantitative/questionnaire' based variety of research on women in general practice and medicine, rather than focussing on women's perceptions of

their own circumstances and experiences.[1] Such perceptions, where they differ from quantitative research findings, will obviously be most influential in determining actions, strategies and beliefs.

Studies have shown the male-dominated nature of medicine as a profession and the uneven distribution of women across the specialties. General practice has been viewed as a suitable specialty for women to work in partly because of the flexibility of working arrangements. It has been shown how male supremacy has been built up through entry into medical school, through training and through entry into certain specialisms and up the hierarchy of power. In addition, the impact of family commitment, both potential and actual, was examined in terms of its effect on respondents' progression within medicine and on how they planned their time.

This study has extended discussion of many of the issues raised in the literature. Chapter 3 examined several aspects of general practice which illuminate the situation for single-handed practice and against which the women GPs can be placed in context. In looking at the backgrounds and training experiences of the women GPs it is apparent that there is nothing in those experiences which seems to make them stand out, at that early stage, from women doctors portrayed in other literature.

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1 Glaser and Strauss suggest that researchers often rely, in addition to qualitative 'grounded' approaches to collecting data, on "questionnaires or other 'objective' methods of collecting and analyzing data. When used for this purpose, these methods do not necessarily lead to greater credibility, but they do permit the insecure researcher to feel greater security in his 'results' without really considering what specific queries do or do not need this additional 'hard' data" (1968: 227-8).

After qualification and during the hospital career, respondents' experiences were varied. As doctors, the women were largely constrained in progressing successfully through the hierarchies of their first choice of specialism. In many cases choices were tempered to meet available opportunities where they presented themselves. While some had always wanted to practise as GPs, others had moved towards general practice at later stages of their careers depending on circumstances. However, it was shown that (in common with other studies) the women made their career decisions and compromises to fit in with family and domestic considerations. The needs of children came above those of husbands and allegiance to their families was very strong. This was so in cases where they had to live apart from their husbands and where frequent moves disrupted their children's schooling.

The expectations of general practice, where the women GPs had made compromises in choosing it, were that its working arrangements would be flexible and stable enough to counter the resulting ambivalence. Mostly though, despite such feelings, the women became enthusiastic about the idea of general practice and the options it would open to them. Those who had been disappointed at their inability to follow specialisms, particularly obstetrics and gynaecology and paediatrics would find such options opened to them in GP work. However, the attraction had also been the generalism of general practice work rather than the specialisms within it. This had implications for later experiences (see below).

General practice was not the only option taken to offset the demands of children and families. Those who worked in community health did so largely as an expedient, seeing general practice as the next stage.

The decision to go into general practice was sometimes facilitated by the fact that the women had followed appropriate specialisms which were a valuable background to the needs of general practice - obstetrics and gynaecology, paediatrics, psychiatry and so on. Others, set about obtaining general practice-appropriate experience from the very earliest stages of their careers.

The relationship of gender to decisions to become GPs is therefore strong and acknowledged by the women themselves. Later developments in their careers which were gender-related (as is shown below), were less readily acknowledged as such by the women interviewed.

The next stage in the women's careers took them from their entry into general practice up until decisions were made to practise single-handed. In this part of the study it became very apparent that a gender relationship to employment persisted. The examination of the experiences of those who worked in groups and partnerships added, it was argued, a new contribution to the current literature on both gender relations and on general practice. The 'negative' reactions against group and partnership practice and the 'positive' attractions to single-handed practice (i.e. financial grievances, personal relationships, continuity and independence) are an amalgam of concepts which have been expressed diversely in the literature elsewhere. This study not only identifies these as a particular impetus for action (i.e. to move into single-handed practice), but analyses the gender basis of such actions. The idea of gender and 'ghettoism' is presented in detail in chapter 7. While an accumulation of factors led the women into single-handed practice - factors which they were well-aware of - the gender implications (while they were sometimes expressed) were less explicitly acknowledged

or understood by the women GPs. An important contribution of this research, it is suggested, lies in the understanding which it gives of the 'ghettoisation' of women into a limited form of general practice. Women are 'ghettoised' within general practice into certain areas of practice in much the same way as they are channelled within medicine generally. In effect, they are given (by their male superiors) what is deemed to be gender-appropriate work. In addition, their perceptions of their 'ghettoisation' are conditioned by the demands of general practice work. Women patients comprise a larger proportion of consultations than do men patients, so that the demand for women doctors (given that many women patients do prefer a woman doctor for some consultations) is considerable. Since women make up only 18 per cent of GPs nationally (in 1986) it is reasonable for their perceptions of general practice to be affected, giving them an unbalanced view of the gender balance of their patients.

Gender-related behaviour was a feature of group and partnership practice in the women GPs' experience and the gender-appropriate work which is **imposed** on women GPs brings about their 'ghettoisation' within general practice. There are some comparisons to be made with the concept of gendered-jobs, 'women's jobs', which have been identified in administrative posts in the health service (Davies and Rosser, 1986; Rosser and Davies, 1987). In effect, the job of 'woman GP' has been feminised and 'gendered' by the process of 'ghettoism'. The particular experiences of general practice were major contributory factors in the women GPs' decisions to practise single-handed.

Another part of general practice which was crucial in the decision to practise single-handed - and central to the organisation of their own single-

handed practices - concerned out-of-hours cover. In group and partnership practice this had been one part of their experience which many women had found particularly stressful.

Women GPs are inevitably under great pressure to organise their home and work life in a way that enables their two roles to be complementary. Out-of-hours cover has been described as the 'link' between the 'public' and 'private' aspects of women's lives, where the one intrudes into the other. This 'time-intruding' link was examined in some detail. The women GPs expressed many negative feelings about their experiences of out-of-hours cover in groups and partnerships, which had contributed to decisions to practise single-handed. On the one hand they were not attracted to going out on night visits because of feelings of vulnerability as women and on the other being on-call for large numbers of patients in a group practice rota was very stressful. In addition, in group and partnership practices they had often shouldered a greater burden in respect of the amount of on-call periods they were expected to cover.

However, the women GPs overwhelmingly took a major responsibility for organising, planning and household tasks. Even where there was a form of role reversal - in two cases the husbands stayed at home - the women were seen to retain ultimate responsibility in their homes. In effect, the amount of time and effort involved in these tasks and in the overview of household events, such as 'negotiating' care for their children where appropriate, was irreconcilable with the heavy demands of group and partnership practice arrangements for out-of-hours cover. Surprisingly, practising single-handed resolved many of the conflicts involved in managing out-of-hours cover and reconciling it with their heavy domestic burden. What was significant

about the move from being a junior member of a partnership or group practice to single-handed practice was that the move restored to the women a major degree of control over their destinies. Single-handed practice gave the women **control** over how they organised their own practices in every respect. This was control that had been fundamentally absent in their previous general practice experience. This **control** was crucial for the out-of-hours cover organisation. Despite the 24 hours responsibility of single-handed practice the women GPs had no necessity to 'negotiate' their time within the practice and with practice partners. They could choose to use the deputising services (where available) or not, or they could make other arrangements, or cover all calls themselves. But, control within their own practices was central to them being able to reconcile their professional with their domestic responsibilities.

An important aspect of out-of-hours cover was the impact which the women GPs' being on-call had on other members of the household. The effect was substantial and occurred in a number of ways. Husbands could be disturbed by night calls, both in terms of their sleep being affected and in terms of their fears of their wives' vulnerability.

Childcare was another perhaps more important problem. It was shown that although being on-call did not necessarily mean being called out, arrangements had to be made to cater for that eventuality. Therefore, at any time that the GP was on-call arrangements had to be made for babysitting for children who were too young to be left alone. This caring task was almost invariably taken on by husbands (where they were present) and done without much question. Nevertheless it was necessary for the wife to 'negotiate' for his time. In these circumstances the effect on

family members was apparent and the 'interface' between 'public' and 'private' domains very manifest. Additionally, husbands were required to act for the doctor in making decisions on her behalf when she was absent. The characterisation of the traditional 'ideal-type' single-handed male 'family' doctor set out at the beginning of this thesis shows how his wife and family were incorporated into his practice. When the single-handed GP is a woman, the involvement of the family seems, in terms of prevailing norms, extraordinary rather than usual. Most husbands also had demanding professional lives which inhibited their taking on this role to the extent that a traditional single-handed male GP would have expected of his wife. Nor did husbands necessarily sympathise or understand the pressures that were caused by this situation. Despite the intrusion of out-of-hours calls and being on-call into family life, it was the control of their own practices which made these pressures easier to deal with. Finch's (1983) work which examines wives' involvement in husbands' work is in effect turned on its head in this research, except that here the traditional wives' support was less forthcoming from husbands both because of their own professional lives and because such support was not a role they expected to have to fulfil. This contributes to further understanding of the notion of the 'interface' between the 'public' and 'private' domains.

Looking further at the part that was played by husbands in the lives of the women as GPs, it was apparent that, contrary to the literature which suggests that husbands and wives working in the same profession are supportive of each other in their understanding of the constraints of that profession, such husbands were no more supportive in performing household tasks than other husbands. In effect, as discussed above, the women GPs performed or 'planned' and 'negotiated' the household tasks and took the

major responsibility for them fulfilling the 'normative' expectations of their roles as wives and mothers. Despite this they persisted in ensuring the 'egalitarian overlay' of appearances identified by Lorber (1984).

It was noted that the single-handed women GPs operated with little ancillary support - separate provision within the practice premises for other members of the primary health care team was largely lacking. It was tentatively suggested that it was the will to provide for other team members which was lacking, because of the GPs' resistance to working as team members on account of the negative aspects of past practice experiences in teams and groups. However, where GPs employed their own practice nurses or nurses/receptionists they found them invaluable. There was, though, resistance from some GPs to making any significant use of health authority employed staff such as health visitors or midwives. This was related to a fear of losing control within their own practices by delegating tasks or risking loss of their single-handed 'family' doctor image.

The examination of respondents' attitudes to women in medicine was illuminating. It was apparent that the women GPs were ambiguous about their own roles as women, as women in medicine, and as women in general practice. For, while on the one hand they mentioned aspects of their own experiences of exploitation as women, on the other hand many of them blamed women for the 'wastage' of training resources and supported a **reduction** of women medical school entrants. This ambivalence mirrors that found in other studies. Despite complaints that they had been overloaded with women patients in group and partnership practice, the women GPs supported stereotypical views feeling that women doctors have a special role to play as regards patients. This was seen not only with

regard to treating conditions which women patients might find embarrassing, but also it was felt that women doctors were more 'sympathetic' and that patients found it easier to talk to a woman doctor. This they recognised as a contributory factor to their popularity in previous group and partnership practices.

It was frequently perceived by respondents that one of the particular attractions of single-handed general practice was the continuity of the treatment process. Not only could the doctor know all her patients, but they were able to see through a whole course of treatment themselves. This was viewed as being particularly beneficial from the patients point of view, too. There was also a very satisfying 'generational continuity', where the treatment of different generations of the same family over a period of time was one of the attractions of general practice, particularly single-handed practices, over hospital practice.

The women GPs did not confirm the view put forward in official reports of single-handed GPs being elderly and avoiding retirement. For the most part the women envisaged retirement in the future, despite the lack of a statutory retirement age. The age range of the GPs was 29-68 years, most were in their 40s or early 50s and therefore several years off the potential age of retirement of 70.

For the most part the analysis did not draw out the Asian women GPs from the main sample which was taken as a whole. Rather, they were the subject of a separate chapter. They differed from other women in that most had intended to specialise in obstetrics and gynaecology, this choice deriving from the culture in which they had received their early medical

education, the norms of sex-segregation holding that women patients should be treated by women doctors. Obstetrics and gynaecology is a male-dominated specialism in the UK and these women had found that the combination of being both women and foreign had meant that they were excluded from progress in this specialism. For these women, the choice of general practice had been a compromise, but they were able to use their experience and prediliction positively within general practice. Where they practised in Asian communities they were particularly popular amongst women patients, who also used them as a source of social contact and comfort. This seemingly demedicalised their practices, which these women GPs were unhappy about.

It was tentatively suggested that the interaction of gender and ethnicity in the Asian women GPs' lives was difficult to unravel, but that gender had been the central or stronger element of discrimination. However, the presence of a white interviewer was seen as affecting the level of self-exposure that the Asian women GPs would allow.

The approach to the research study, data collection, analysis and writing up of the thesis was described by 'personal account' and analysed in chapter 4 as an extension of the 'grounded theory' approach of Glaser and Strauss (1968). The input of feminism in making women noticed was explained as was the interaction of the interviewer/researcher in the reseach process. Whilst this research has used orthodox research methods, it has been informed by an acknowledgement of the dynamic nature of the research process. This has penetrated the analysis and writing up of the research and beyond. And as feminist research, this process continues as feminism (and the researcher) develop in tandem.

In conclusion, the contribution that this study makes to the current literature on gender and general practice can be summarized as follows:

(1) The concept of **'negotiation'** was added to Lorbers' (1984) thesis on 'planning' and 'egalitarian overlay' in the domestic lives of women doctors. However, **'negotiation'** was also identified as an aspect of general practice in groups and partnerships which limited reconciliation of the two roles.

(2) The **'interface'** between the 'public' and the 'private' lives of women was discussed in gender terms by describing women's strategies for balancing extreme pressure in both the 'public' and 'private' domains.

(3) The concept of gender and **'ghettoism'** was introduced as an extension of that of the 'gendered-jobs' thesis.

(4) A characterisation of the traditional 'ideal-type' male single-handed **'family'** doctor was identified and it was suggested that this was particularly attractive to women because of the 'control' element it engendered (see point (6) below), despite its increasing rejection by male GPs.

(5) The interaction of **'gender'** and **'ethnicity'** in the lives of Asian women GPs was assessed and gender was tentatively placed as the stronger element in the discrimination which they had experienced.

(6) The importance of **'control'** in the lives of women was identified and analysed in terms of gender in general practice.

(7) In terms of feminist methodology this thesis has confirmed the analyses of other feminist writers. The continuing effect of a changing analysis of feminism and the personal development of the researcher to the research process, analysis, writing up and beyond, are explained by the personal account of the research.

The policy implications of this reseach mainly concern training. An awareness of the 'ghettoism' of women GPs and the management of the 'interface' between the 'public' and 'private' domains could profitably be heightened by some introspective assessment and appreciation by GPs of their own practices and working relationships. This should be included as a part of the training for GP trainees as well as for established GPs, who could reassess their practices at frequent intervals.

Finally, there are several areas where future research initiatives might follow on from, and extend, the present investigation. These include the following topics:

(1) a study of women GPs in groups and partnership practice, following the same approach to the present study, but spending more time in observation, interaction and involvement in the practices per se.

(2) a study of feminist doctors which would identify the strategies of more gender-conscious women to oppression and to their reconciliation of the 'interface' between the 'public' and 'private' domains.

(3) a study of women patients and women doctors to assess the 'woman to woman' relationship in medical practices, its benefits and costs.

(4) a comparative study of women in professions who have on-call or out-of-hours cover to contend with, in terms of both the effect on household organisation and in terms of the vulnerability of women who do home visits (eg. estate agents - bearing in mind the Susie Lamplugh case, and social workers - the Frances Betteridge case).

(5) a study of women doctors in other specialisms than general practice to assess whether or not women are channelled within specialisms into 'gender-appropriate' work.

APPENDIX A

Letter sent to GPs

Dear Dr

I am writing to ask whether you would be willing to be interviewed in connection with some Social Science Research Council funded research I am carrying out into women GPs in the Midlands. The interview would involve about an hour of your time and I would hope to discuss your career to date, how it feels to be a woman doctor in general practice and so on. I am particularly interested in your experiences of practising alone as a single-handed woman GP. However, any suggestions and insights you are able to offer about being a woman GP would be useful.

Your name has been picked at random from lists provided by the Family Practitioner Committee, and I would stress that anything you say would be strictly confidential, and naturally no questions will be asked which impinge in any way on matters of professional confidentiality.

I shall follow up this letter within the next few days with a telephone call to arrange a suitable time for the interview.

Many thanks - I look forward to meeting you.

Yours sincerely,

Barbara Lawrence

APPENDIX B

Single-Handed Women GPs' Interview Outline

The following is the interview outline used. It was compiled in this way after completion of the six pilot interviews and used as a guide only. As discussed in chapter 4, the interviews varied considerably in shape and structure.

GENERAL QUESTIONS

Age
Place of birth
Secondary education
Parents and family connections with medicine
Children
Spouse's occupation

CAREER - chronologically

University

Which?
clinical - where? (if different)
problems - academically
- clinically
relationships - vis a vis - patients
- other students
- teaching staff
career advice - overt
- covert

After qualification

Housejobs - specialisation
- and other career jobs before GP

GP

why and when
different practices
group
single-handed - how long in this practice
training for GP work
part-time work
remuneration

Single-handed practice

organisation
size
patients
ancillary/secretarial staff
support facilities

how did you get your practice?
deputising service
trainer
relationship with patients
relationship with support staff
remuneration
difficulties (in getting s/h practice - MPC policy obstructiveness)
single-handed practice in health centre

DOMESTIC

how duties shared
how spouse sees medical career
effects on marriage/relationship
reconciling work and domestic life
domestic help
effect on children
leisure activities
on call

GENERAL OPINIONS/ATTITUDES

Attractions to medicine
Attractions to GP work
Expectations realised

Advantages and disadvantages for women in medicine
Advantages and disadvantages for women in GP
Advantages and disadvantages for women in single-handed general practice

Satisfactions and disappointments

Retainer Scheme
Wastage
Hospital Practitioner Grade - for GPs

Home visits
Break in career - for children or whatever reason - disadvantage?
Race - ethnic minorities
- for ethnic doctors - problems with different races?

Would you have considered GP work if not married/not with child
Has this affected aspirations in career terms?

Ambitions and aspirations for the future

APPENDIX C

Contextual Outlines

The 'contextual outlines' which follow are constructed on the basis of information from the interview transcripts, observational notes and analyses of the 29 single-handed women GPs. A page is given to each GP in which the background information, medical training and experience, general practice - past and present, and attitudes and aspirations of each are presented mostly in their own words. It is intended that they should give some shape and meaning to the GPs' lives as both doctors and women.

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
52	Asian (India)	Widow	Doctor - GP	5 (all adult)	"It was entirely my responsibility .... My husband never believed in women's work ... he didn't believe in helping in the house"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors, but "After I graduated there are quite a few"	"I always wanted to be a doctor... to relieve the sufferings ... that is my motive"	Not given	"It was all plain sailing"	(1) 3 years in hospitals, (2) GP, (3) had own nursing home (4) Came to UK after 10 years after qualifying. In UK - obs/gynae for 10 years. (5) To India for 4 years. (6) Back to UK and into GP because "in the hospitals there was a high racial discrimination"	Obstetrics and Gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In practice with husband	Attached to home	Good	One receptionist for morning and evening surgery. Some use of Health Visitor.	1,000	"I'm on call 24 hours a day ... and 5 days a week... In the beginning I was on my own every day of the week, every week of the month, and every month of the year ... for 2 years I carried on like that, but recently I've got a rota with another village doctor for the weekend."

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"My patients mostly come to me because I'm lady doctor .... women are very patient with patients and really tolerant habitually .. and they can give more time and understanding to the patients, especially psychological patients"	"I think it's a disgrace and disgusting ... it's hard work to be a qualified doctor ... It's better not to qualify ... in the first place"	"My satisfaction is ... relieving the sufferings"	"I have completed my life ... I was wanting to retire and go to the African bush or somewhere there, just to give the professional benefits to others."

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
49	Asian (India)	Married	Engineer	4 (16 - 2)	" ... the children, clearing up, dressing and things like that ... its mine ... but outside shopping and going round here and there ... is his responsibility ... inside cleaning and cooking I do it ... outside cleaning, garden... he does it ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"It was always my ambition"	Not given	"It was all quite all right"	(1) Obs/gynae (2) ENT (3) Ophthalmology (4) to UK one year after qualifying, house jobs (5) GP because difficulty getting hospital jobs	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Converted house	Poor	One receptionist for morning surgery. Own full-time practice nurse.	3,000	"I stay on-call ... not 24 hours ... sometimes I give it to the deputising service, and sometimes if I'm going away or something."

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"The advantages are that at least you've got work satisfaction, as well as a good career"	"... they are trained and if they don't do it that's a waste of resources ... I've seen some of them, once they go out of it, it's difficult to come back"	"I'm satisfied with my practice"	"I will try to carry on"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
67	British	Single	n/a	None	"I always had a housekeeper ... I always had help, all the time I was here. I think this is one of the things doctors can afford ... a full-time housekeeper ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Cousin	"I wanted to be a vet ... and my father said no, you can't be a vet ... they don't have women vets ... so eventually I said I'll change to people"	8%	"I didn't have any problems"	(1) Paediatrics and other house jobs for 2 years (2) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home	Did not see surgery, but house comfortable	Own full-time practice nurse	Not given	Has another GP who does most of her on-call visiting

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I think the advantage to be a woman ... a general practitioner ... you really ought to have another woman in the house if you're a man ... I think also ... kids aren't frightened of a woman. I suppose in male complaints ... it's for a man ... nice to have a man doctor"	"I think it's a pity to put all that money into training and then not use it ... the poor old tax payer"	"... anything you feel won't get better and you thought they would. I think that's the only thing"	"I'm retiring soon. I don't know (when). I can go on until I'm 72 I think. I don't know"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
34	British	Married	1. Chemical Engineer 2. Ex-pet shop owner - now at home (role reversal)	1 (3)	Role reversal. "... it's a mixture really, I tend to buy the food because I happen to be close to the shops... Cooking, he probably does 3 or 4 nights a week ... and when I have half days ... I'll cook ... there's no definite line as to who does what"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors. "My father kept a pub"	"I liked what I saw on the tele ... of a vet's life ... then I became interested in forensic medicine and, for that one had to be a GP. I had a father who didn't particularly want me to go into medicine ... so that spurred me on even further"	25%	"There were a lot of men who had lower grades than me, a lot of people who had far more money and different backgrounds from me ... that took some years to come to terms with"	(1) General medicine (2) General surgery (3) VTS and GP	Dermatology and GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF HOURS COVER
In partnership	Shared practice premises	Good	Two receptionists (p/t). Use of Nurse and Health Visitor.	2,000	"... as regards the on-call, I'm not in an on-call rota, I'm on call for 365 days of the year (day and night)"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS IN CAREER	AMBITIONS/ASPIRATIONS THE FUTURE
"I suppose the hours ... it's fairly flexible ... I think it would appeal to women ... General practice has got a lot more to offer ... (but for it to work, you have to find colleagues who you can get on with"	"I think ... it's wrong that there should be 50:50 intake now, although I'm a woman, I'm sure they'll be far more wastage in future	"... on reflection (going single-handed is) probably the best move that he ever made me do.."	"I don't really have any ambitions ... I've achieved what I want"

DOCTOR 5

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
37	Asian (Sri Lanka)	Married	Solicitor	4 (14 - 7)	"... in between surgeries and ... calls, I've got a little time to go home and do a little bit of housework and ... some cooking if possible, but ... my husband and I both try and do it over the weekend ... bulk cooking. The housework we ... share ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"I liked dealing with people and ... I was always interested in the human body, and I wanted to know everything about it"	20%	"After ... two years of having to dissect the human body ... we really looked forward to the time when we were going to see our patients, for the first time"	(1) Govt. service- moving round different jobs (2) to UK after 7 years for further training - ophthalmology (3) GP - so didn't have to move around	Ophthalmology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Converted house	Fair	Two receptionists (one for morning and the other for evening surgery)	1,000	"I try to do two nights a week, but the rest I give over to the relief agency ... I don't do any weekends I give all that over to the deputising service"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... when it comes to a real ... emotional problem or anything like that (women) prefer to have a nice woman to woman chat, and they prefer to have a woman doctor for that ... I think the general population ... their image of a doctor is a man"	"I think that is a waste really ... I think they should practise something for a few hours a day"	"It's funny, I can't say I liked one specialty more than the other, but whatever I did I liked"	"... if I could build up the practice ... I'll be quite happy"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
50	British	Married	1. Doctor 2. Teacher	3 (26 - 15)	"I've always done them ... I've had a cleaning woman at least 3 times a week, and when the children were very small ... 5 times a week ... she did the washing and ironing ... but I did the cooking"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors. "(My father was) the editor of a newspaper ... (then) he became a minister"	"My parents wanted me to be a medical missionary ... and (they) wanted my eldest brother to do it and he didn't ... I think it was competition really"	Not given	"I did have one (baby) ... just as I was doing my finals, so I resat my finals ... and there was this baby in a pram ... nobody had ever seen anything like it before"	(1) Geriatrics (2) General surgery (3) Obs/gynae (6) Community health for 5 years (5) Psychiatry (6) GP	Psychiatry

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Not seen	Not seen	One receptionist	1650	Covers all her own on-call except at times when she is working for the deputising service herself

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I found it an advantage being a woman as far as dealing with patients go ... patients like women doctors ... I'm sure that women (doctors) are disadvantaged in surgery and things like that"	"I think it's an awful shame"	"I didn't expect to be working so hard when I was 50 ... I thought all doctors were rich by the time they were 50." "I think when the patients turn round and say thank you, that's nice, and also I'm conscious of having made a diagnosis or a correct decision ..."	"I think I'd like to try and plod on and get a trainee here ... I'll retire when I'm 65"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
31	British	Married	Doctor - GP	1 (15 months)	"... actually J's very good ...I mean he'll do anything I ask really. Sometimes he doesn't use his initiative ... we've always shared domestic chores ... although I see it as my responsibility to make sure the home is organised and that there is food in the cupboard"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
I have an uncle ... who's a consultant ... and two great uncles ... who are medics". Brother	"I have a brother who's a medic ... and it influenced my choice ... I think I always wanted to work with people"	25%	"I think just being a girl, they sort of tended to be a bit easier on you I think ... I never found being a woman medical student a disadvantage ... I never wished I was a male medical student"	(1) General medicine (2) Casualty (3) Obs/gynae (4) Paediatrics (5) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None previous (registered single-handed)	Student health centre	Good	Two receptionists and two nursing sisters	Student population	"... we do a night a week on-call and then a weekend in five, which is a Friday, Saturday, Sunday weekend"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"There is a little bit of prejudice in respect of ... having babies and what have you ... Pursuing a surgical career, there's just no way that as a woman you could survive if you were married and trying to ... combine home life and hospital life"	"I feel that it's perhaps wrong of people to criticise women that are wasting their education ... I think that's OK. I think that's her right, her privilege, she can do what she wants"	"I think satisfaction is just purely job satisfaction ... My only disappointment was the behaviour of my colleagues over my pregnancy ..."	"My ambition is to do my MRCGP ... I suppose I'll just potter on the way I am trying to just be sort of happy in my job and using my money to go out and enjoy myself ... I might in maybe five or six years consider another practice"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
53	British	Married	Doctor - radiologist	3 (23, 20, 18)	"... he's not the kind of person who offers to do things ... but in fact I do virtually all the regular housework, he does chores ... jobs that I tell him need to be done"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors.	"I went into medicine with the idea of being a medical missionary ... that was quite definitely a sense of vocation"	15%	"E... is a place where much more emphasis is put on the academic side ... they make sure you get a good academic grounding"	(1) General surgery (2) General medicine (3) Obs/gynae (4) Paediatrics (5) Medical missionary (9 years) (6) Back to UK and GP	Medical missionary and GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Converted house	Good	One receptionist. Use of nurse, Health Visitor, Midwife, District Nurse	2,000	"... using the deputising service as an answering service and very very occasionally to take calls. It's worked out very well ... I say very occasionally, but in fact I get very few calls out-of-hours ... And weekends I'm always on-call"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... one of the advantages in the flexibility which does enable you at every stage, to combine medicine and bringing up a family. And I think women find it easier to get a rapport with people in trouble than men do"	"I think it has to be ... acknowledged in the allocation of places in medical schools ... a bigger proportion of places should go to men than to women"	"I think my main satisfaction is ... being in a position to get alongside people in very significant events of their lives, and to be a help to them"	"I don't look forward to the prospect of retiring... I see myself here, and hope that I shall expand sufficiently to make this a two doctor practice"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
38	British	Married	Electrical Engineer	2 (10, 5)	"... he's very good, you know he'll cook ... look after the children ... doesn't actually do washing or ironing ... apart from that he is very good. (But) I feel that it's my responsibility"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"I was quite tiny when I decided I was going to be a doctor, I was about three, and I never changed my mind"	30%	"I don't think I ever had any problems"	(1) Casualty (2) General medicine (3) GP	None

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home (plus a branch surgery)	Good	One receptionist and one nurse/ receptionist	3,200	"I use the deputising service ... you can decide on any particular day whether you want them to cover you for that night or not ... so it's a perfectly flexible life ... I don't do any evenings"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I suppose you do get the odd patient who will say that they want a woman doctor ... I wouldn't say that that's a big thing"	"It is a tremendous waste, but I wouldn't really have thought that it was a big problem. Certainly ... all my women friends that are doctors are still practising ..."	"I don't think that there's anything that I would really rather do than what I'm doing"	"Just to stay here and do the job as well as I can ... I'll probably be here until I retire"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
40	Asian (India)	Married	Doctor - GP	2 (14, 9)	"... it is you know only ladies' work, my husband doesn't do any domestic work as such, although sometimes he does help me nowadays ... if I am busy or stuck ... but mostly it is my responsibility to finish my housework"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Uncle. "My father was a teacher"	"I wanted to become a doctor just to treat patients ... so nobody suffers ... it's a good line for ladies"	All women	"We didn't have that much experience (with men) as we had with the ladies"	(1) General medicine (2) Obs/gynae (MD) (3) to UK after 4 years (4) GP - because living apart from husband	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership with husband (but registered single-handed)	Attached to home	Good (but cramped)	Two receptionists (one for morning and one for evening surgery). Use of nurse, District Nurse, Midwife, Health Visitor	1050 (but 2200 with husband)	Uses deputising service quite a lot, especially at night, but also shares on-call with husband

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... it is a very good line for ladies"	"I think they should not really ... give up ... nowadays you can always find somebody to look after your child"	"I'm happy that patients are happy". "... if I would have stayed there (India) ... I would have become lecturer, then reader and professor ... so I regret that sometimes"	"Expand the practice ... and just make my children something, and that's all"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
44	Asian (India)	Married	Government Service	2 (18, 15)	"In the evenings, most of the time ... my husband is the one who gets the meal ready, and when I'm off after I do everything. And during weekends most of the time I do all the cooking and washing and everything, but I get an awful lot of help from my husband"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"I always wanted to be a doctor ... One of my sisters used to be very ill ... and I used to look after her an awful lot ... and seeing the doctors and nurses ..."	Not given	"No problems"	(1) obs/gynae (2) government service (3) to UK after 7 yrs - SHO in obs/gynae (4) GP because of children	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	In Health Centre	Good	One receptionist. Use of Nurse, Midwife, Health Visitor	2,500	"I'm helped by the deputising service, which is ... extremely helpful ... if not because of them I don't think I would have been able to do it, to practice ... I used to do an awful lot of night calls but I don't do now"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... specially women patients ... they prefer a woman doctor for their private problems ... a woman wants to confide to another woman more than a man ... And disadvantages are many ... if you are married ... your attention is divided	No comment given	"I'm quite happy with my practice. I very much like doing my work on my own. I think patients very much like to see one doctor all the time and not divide it"	"... if I could do my MRCGP ... and of course I would like to carry on working as I am, and if I could get more holidays"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
47	Eire	Married	1. Doctor 2. Teacher	2 (21, 19) from 1st marriage	"... I've got a microwave and very big freezer ... and I keep that stocked up, and ... I leave something out to defrost, and put it on ... But my husband is very good with cooking, he sometimes prepares the dinner for when I come home, it's just that it's not often ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"I had realised that doctors were fairly well off, even during the war when I was a small kid ... I'd always had that sort of idea"	11%	"...my surgery professor was very anti-women, and I had great difficulty with him trying to get through my finals"	(1) Surgery (2) Paediatrics (3) Brain surgery (4) ENT (5) Dermatology (6) Obs/gynae for GP (7) GP - because had enough of hospitals	Paediatrics - GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Not seen	Not seen	Not given	2,800 (down from 3,300)	"I don't have on-call, I have emergency service ... and I am covered for capitation ... and I have 7 in the evening until 7 in the morning cover ... I never do any nights"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"You've got to be a very good organiser ... work out your priorities ... work out who is going to suffer ... I think it's by far the best job (GP) for a woman to have ... I think surgery is terribly demanding. If you're a woman surgeon, it's very difficult (to) have a family and a husband and stay at it"	"I think that's a terrible wastage, and I think we really want to press for part-time jobs"	"Disappointments ... that one cannot in England practise properly, practise GP medicine, you can't really do preventive medicine not with the number of patients." "It's lovely to sort somebody's health out ..."	"... at the moment I would like to run the practice down a bit ... I would love a 9 to 5 if we came off the self-employed bit ... I think we ought to finish at a certain time"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
44	Asian (Pakistan)	Single	n/a	none	"(Domestic help) ... there are two, one comes once a week, and the other she comes twice a week and also I've got a gardener ..." a gardener ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Brother, sister, brothers-in-law and nephews	"My father always wanted me to be a doctor ... and that is built in my mind"	Less than 10%	"I think they respected (us) more being a few ... they respected girls ... And here it is different"	(1) Obs/gynae (2) General medicine (3) GP (4) to UK for further education in obs/gynae (5) Surgery (6) GP - unable to get post in obs/gynae	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Converted house	Fair	Two receptionists (one for morning and one for evening surgery). Use of District Nurse, Health Visitor, Midwife.	2,550	"On-call ... from 7 in the evening for emergencies at night, the call service we have that, half days they take it after 12 clock, on Thursdays, Saturdays, weekends they take it over, so I pay them"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... some patients do prefer to come to see a woman doctor, even men ... Only there is no Asian male, they send their children and wives to me, but for themselves they feel a bit themselves embarrassed. I think they prefer a male doctor"	"... if you have a long break and coming back into medicine again, it's a problem"	"... some patients, no matter what you do with them, they moan and groan and then just complain ... you can sometimes carry on and they'll never be satisfied"	"Whatever I want I have got it. I don't need more than that"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
45	British	Married (Recent)	Businessman	2 stepchildren (21, 9)	"I've got a very very good old daily help ... she's in every morning by half past 8 ... She does all the cleaning up, and usually the cooking of the evening meal ... she does all the dishes, but my husband's a very very good cook, so we both have cooking sessions at weekends"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Uncles, cousin. Mother-teacher.	"I think it was probably my mother that was the influence ... I think she would have quite liked to have done medicine herself ... I was just interested in it from a very early age"	20%	"I had difficulties getting in in the first place ... we had to have very much higher standards of education than the boys to get in." "You felt very much in awe I think of your teachers."	(1) Acute medicine and geriatrics (2) Surgery (3) Obs/gynae (4) Rheumatology and drugs research (5) GP - got married and didn't want to travel any more	Surgery

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None	Converted house	Good	One receptionist/ nurse. Use of Midwife, Health Visitor, District Nurse	1,000+	"... at night the deputising service take over and at weekends ... but on alternate weekends another single-handed male GP locally, he does alternate Saturdays for me, and I do it for him ..."

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... there were various surgeons and physicians in E. who wouldn't have a female houseman ... but (now) they have often said to me that they would choose a female houseman in front of a male because they're more conscientious"	No comment given	"Well the satisfaction is that I love the job, I mean I really do and you know it's just what I want to do. I don't think I've had any disappointments ..."	"Just to slightly increase my practice, and to do my hospital medicine, and to just run my practice well ... until I decide to retire"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
41	Asian (India)	Married		2 (7, 4)	"It's definitely my responsibility"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Uncle. Mother-lawyer, father-engineer	"I just fancied it ... I wanted to be a doctor ... and I saw to it that my subjects were such that I would ..."	50%	"... until my second clinical year I got away without examining a male patient"	(1) to UK immediately after qualification (2) general surgery (3) general medicine (4) casualty (5) GP	GP or paediatrics

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Lock-up shop	Very poor	Not given	1200	Uses deputising service most nights and weekends.

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I heard the consultant did not like women, and he would not interview women and (I know women who) were quite sure that they didn't get the job because they were women"	No comment given	No comment given	"Just to carry on practising on my own like this"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
59	British	Married	1. Army 2. ex-accountant - now at home (role reversal)	3 (adult)	Role reversal. "I run it in as much as I organise ... what everyone does ... shopping ... shopping for clothes and things like that, I have to do that. I've always sort of brought the children up as well ... bath them, feed them and everything"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors Mother-teacher	"I just wanted to be a doctor, I don't know why"	All women	"... you're suddenly presented with a man patient, you examine them as far as the waist and you just daren't, you know, terrible ..."	No housejobs - straight into GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
Assistant for 1 year, but single-handed for 30 years	Attached to home	Good	Husband-receptionist, one cleaner. Use of District Nurse, Midwife.	1300 (down from 2000)	"... until three years ago I was on call every minute of every day and every night and every weekend ... I did 30 years, I was at breaking point ... Then suddenly three years ago they decided to take over H ..., so I jumped at it and joined the deputising service ... (I use them) every night and every weekend. It's marvellous"

ATTITIDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... when I first came here, there'd never been a woman doctor in H ... Yet they simply flocked, the woman that'd had horrible things wrong with them for years with them for years and daren't go to a man doctor ... (but) they've probably got a bit more respect for a man doctor than they have for a woman"	"I think it's an awful shame to take a place (from) somebody ... who really wanted to be a doctor"	"I try to think of myself as a family doctor. I'm growing up with patients, I've stayed in one place for all these years, and I've grown up with them... and being on my own as well, I mean, (when) they come here, I'm going to see them, not anyone else"	"To carry on. Stay as I am. Still be on my own and I'll be quite happy. As long as the deputising service still holds good"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
68	East European (Czech-oslovakia)	Widow	Physicist	1 (adult)	"I had the cleaning ... done for me, and the meals, but I ... did shopping weekends ... I haven't found it difficult, it was a bit of a hectic life ... I just have it nice and easy now in comparison ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Sister - plastic surgeon. Father-lawyer	"Originally I wanted to study chemistry ... I thought I would rather meet people than to work in a laboratory ... and I thought it would be ... nice to work with people"	30%	"I haven't had any problems"	(1) to UK immediately after qualifying (2) midwifery (3) medicine and surgery during war (4) 5 years break for child (5) GP	Gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home	Good	Two receptionists. Use of nurse.	2,500	"I transfer calls to the deputising service when I'm out, but when I'm in, even if it's my half day I answer calls"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"It depends on the doctor, not on the sex"	"I was wasted ... when I came to England ... I took a midwifery course ... because we were not allowed to work as doctors (as foreigners)"	"Satisfaction is when people have been helped, and I know that it was ... through me, that I helped them ... that satisfies me very much"	"It's a problem ... my future is a problem, not serious problem ... well, I'm just accepting it (retirement)"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
46	British (Chinese)	Separated	Doctor - psychiatrist	4 (2 adult and 21, 19)	"I had the idea that ... wives are somewhat subservient to husbands and ... were responsible for the running of the house ... husbands weren't expected to take part in any of this ... but this isn't essentially myself, so I always had this conflict about having my own ideas ... to try and match that up with my ideas about being a wife ... I could never really resolve that conflict ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"My mother and I decided when I was about 10 or 11 ... I suppose its a sort of feeling of ... contributing something to a community ... and that's why I chose general practice"	Not given	"... I happened to conceive three times, but that wasn't really a problem for me because I happened to have them in the holidays..!"	(1) 2 house jobs (2) SHO psychiatry (3) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None - except locum	Attached to home	Good	One receptionist. Use of Health Visitor, Midwife.	1532	"Deputising service? Whenever I'm out which is probably one evening a week ... and (if) it's late at night and I'm afraid to go out alone"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... at one time I thought of doing surgery ... and I decided against it because ... it would mean giving up everything in one's life because surgery's such a competitive field"	"I think the intake should be ... two thirds men, one third women ... I think that ... would be fair enough"	"I suppose really the satisfactions are ... sitting in here, somebody comes in with a problem, and you understand the problem, or you make the diagnosis ... and you know the treatment ... that's very satisfying"	"I've got what I want from the point of view of the practice I started myself, and I organise and run the way that I like"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
44	Asian (India)	Married	Doctor - GP	2 (13, 10)	"I've got a lady coming in who looks after my children, she collects my daughter from school ... and then ... my son, and then does as much of the housework that I want her to do ... that eases my burden quite a bit. I just get home and do the little cooking that is essential ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Aunts, uncles, 14 cousins "Generally it was the men that went into business ... most of the girls decided that they wanted to go into medicine"	"Basically it was my father ... I was the brightest one in the family and he always said he'd love me to be a doctor if I could make it ... so I chose medicine as a career	10%	"It was difficult for those who'd come from different parts of India ... because they couldn't understand, because the language ... is spoken with ... a different dialect ... or different accent, and that gets difficult to understand, but I've never had any problems"	(1) Medicine (2) Surgery (3) Obs/gynae (4) to UK after 3 years for further education in obs/gynae (did MRCOG) (5) clinical assistant-ship - maternity/ante-natal clinics (6) GP - too competitive to get consultant post in obs/gynae	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home	Good	Two receptionists and own practice nurse. Use of District Nurse, Health Visitor, Social Worker.	2200	"(I use the deputising service) if I'm out socially, or if I'm held up, because being on my own, if I'm doing one visit and there's another emergency, I do use the deputising sometimes, if I'm tired or if I feel like it"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... advantage in that if the person has the ability I would say there's no reason why a woman or a girl ... can't have medicine as a career just as a man can ... But a woman has the extra added responsibility of looking after a family"	"I think it depends basically on the individual lady, if you have one or two (children) you can easily manage"	"The main satisfaction is getting a nice practice in a good area where patients are cooperative and I think I've just chosen the right spot to practise in"	"Things to stay as they are"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
29	British	Divorced - cohabiting	1. Drug rep 2. Solicitor	None	"The house is always pretty much of a tip ... my boyfriend does most of the work ... I suppose we have takeaways four or five times (a week) ... or anything that can be cooked in 10 minutes"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors. "My family were all working class"	"When I was little, the best job I could think of was medicine ... and we had a family doctor who was a woman ... and I was good at science"	Not given	"I think I was a bit embarrassed at first (with men patients) but no particular difficulties"	(1) General medicine (2) General surgery (3) Pharmaceutical research (4) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	In child health clinic premises	Good	One practice manager and three part-time receptionists. Use of District Nurse, Midwife.	3,000	"I don't usually finish surgery 'til about 8, and I'm in the area still 'til about 9, so I suppose its most of the evenings, and then every weekend evening, but I do most of my own day calls during the weekends ... I 've got a large list, and I couldn't cope with having to get up at night as well"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"The disadvantages I think are the ones that women have always suffered from, a lot of patients think they can take advantage of women a little easier than men"	"It must be an appalling waste ... a lot of women I went to university with never really had any long-term ambitions to be full-time"	"... it's a satisfaction being my own boss, I mean I can do exactly what I want to do ... I like that aspect of it"	"I hope that as I can build up the private work I can reduce the NHS commitments, and I want to find a partner to do the afternoon surgeries"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
48	British	Married	1. Doctor-GP 2. Businessman	8 (from 1st marriage) (7 adult, - 12)	"I've always had au pairs, and ... daily helps or a woman to do the housework ... it was a practice house ... The only disadvantage of that was, if I was in the surgery ... and some crisis happened in the house, they would ring me, they wouldn't ring P ... he wouldn't have expected to have been asked"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Father GP	"I was very young when I decided ... I suppose my father being a doctor, and I admired him ... I'm sure that was what made me decide"	Not given	"I got married as a student ... I had three children before I qualified ... my surgery, I had to repeat that, but that was all"	(1) ENT (2) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Converted house (previously attached to home)	Not seen	Four receptionists (all part-time)	3,000	"I use the deputising service ... I have an option, and I use it sort of one weekend in three definitely, but I pay for the full commitments so that I can use it if I need to, say if I felt very tired"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"The advantage is that it's an equal profession, we are treated equally, or should be ... And if a woman wants to be a surgeon she has to work very hard, and I think it's very demanding to devote as much time to your career as a man has to, because a woman's career really is not all her life ..."	"I think the wastage is terrible, I think there should be about one third female and two thirds male, which is about what it was in my time ... they should perhaps sift the women much more keenly"	"I haven't any disappointments or satisfactions, I'm just quite content with what I'm doing"	"I suppose just to go on working and enjoy it and be quite happy, that's all"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
52	Asian (India)	Married	Architect	3 (adult)	"It was very fantastic when I first came ... I waited for the maid to turn up to the house to tidy up ... and my husband said you'd better get up and do it yourself ... they don't have maids here. ... It's a waste of time isn't it if a doctor has to keep on washing up dishes, where she can do with concentration with looking after patients..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
"The whole family is doctors"	"From a very early age, from the age of 4, I wanted nothing except for being a doctor"	Not given	No comment given	(1) women's hospital (2) paediatrics (DCH) (3) to UK after 3 years to do MRCP (paed) (4) subnormality hospital (5) psychiatry (6) 6 months SHO for registration (7) 3 years registrar subnormality hospital (8) GP - because had to keep moving around	Paediatrics

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None	Converted house	Very poor	Two receptionsists (one for morning and one for evening surgery). One cleaner. Use of District Nurse, Midwife, Geriatric Nurse, Paediatric Nurse.	1600	"I do use the deputising service, only for emergency night calls ... alternate weekends, only night calls I give it up to them, day calls I do myself"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... female doctors especially are very sympathetic ... In our country educated women are respected ... and it's much easier to handle there and do the work ... in this country there's not much respect for women"	"Wastage should be prevented ... there should be more creches ... attached to the hospitals"	"I wish I had better patients, a few more, where I can practise just medicine for its own sake, rather than just the social problems"	"I would rather stay here only and finish off ... and retire ... (then) I want to go off somewhere in the warm..."

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
49	British	Divorced	Vet	2 (adult)	"I did them all, I mean the lot ... The garden was his and the house was mine really ... I mean there were several years when I was doing all my cleaning and everything ... doing the lot, preparation of meals and the lot, it was ... exhausting to put it mildly. He wasn't a very good father at all ... In dire emergencies I could leave them with him, but that was only the only time."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Father-GP	"It's one of those silly things ... I think somebody at school told me ... I'd never make it, so I decided I'd prove them wrong"	15%	"I had quite considerable problems coping with the course. I had I suppose a depression about half way through ... and that really was a bit disastrous as far as my exams were concerned"	(1) 2 house jobs (2) SHO casualty (3) Community health for 10 years (4) GP	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership (now has p/t assistant)	Attached to home	Good	Three part-time receptionists, one part-time secretary. Use of District Nurse, Midwife, Health Visitor	3,000+	"I (use the deputising service) but not more than one night a week, and alternate weekends ... and I find the answering service very good indeed"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"... the men who don't like coming to a woman, I don't think would outnumber the number of women who don't like going to a man"	"It seems a tremendous waste of money ... I think that ... a reservoir of people who've got a basic training, can go back and get a sort of refresher ... brush up on techniques ..."	"I suppose basically it's just job satisfaction ... it was rather exciting the first job I'd applied for ... as a single-handed practice, to be able to get it, without having all the disappointments of being rejected and rejected"	"... nothing very exciting, just to run a practice efficiently and to practise good medicine ...that's what I enjoy and I would like to continue to do that ... Hopefully it might build up a bit ... but not too much ...

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
50	Asian (India)	Widow	Doctor	3 (adult)	"I have help"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"My husband died very young, and I wanted to do the work he would have done if he was alive ... I was 17"	12%	"Some would not let us examine them unless we have a male student with us..."	(1) Housejobs (2) Family planning (3) Pharmacology demonstrator (4) to UK after 4 years for further education (tried FRCS general surgery) (5) paediatrics (6) obs/gynae (7) GP	Surgery

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None	In health centre	Good	Two receptionists. Use of health centre staff e.g. nurses etc	2,200	"(I use the deputising service) one or two nights, and then weekends. I usually am there on the phone all the time, because I like to be available to my patients"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"Married life and being a doctor, the two things don't mix well ... a girl should be single to do it"	No comment given	"it's satisfying work ... if I make the diagnosis right and I could do something for that person, if I save that person, I do feel good"	"I will continue as long as my health holds, or I drop dead ... I will continue to practise unless it is that we have to retire..."

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
32	British	Married	Articled clerk (solicitor)	2 (2½, 4 mths)	"We need a cleaning lady I think because neither of us ... take responsibility for it ... I suppose I do most of the shopping and things ... and I do all the weekday cooking ... but he does the washing up in the week ... B's rther got out of the habit of cooking you see ...

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Father-neuropathologist Mother - psychiatrist	"I didn't have that much experience of it from them (parents), they didn't bring it home, they didn't encourage me to do medicine, but in fact it probably was (an influence)	30%	"I dropped out half way through and took three years off ... I just couldn't cope with the emotional demands of the clinical part of the course ... I felt I'd drifted into it ... I found it much easier second time around"	(1) General medicine (2) General surgery (3) Paediatrics (4) Psychiatry (5) Obs/gynae (6) 1 year VTS for GP	Paediatrics or psychiatry

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership (still, but registered single-handed)	Not seen	Not seen	Two receptionists. Use of District Nurse and others	9,000 (between 5)	"What I do is five morning surgeries with visits to do and one afternoon on-call from one 'til seven ... I don't do any nights" (in rota)

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"It's a huge disadvantage being a woman and being of childbearing age, it's very difficult to get anybody take you on ... because they think you're about to leave to have children	"... there's relatively little of it now ... because you can work part-time for a few years and then go full-time later quite easily in some parts of medicine, as long as you don't want to be a brain surgeon"	"I just enjoy the job ... in general practice I'm beginning to enjoy and look forward to the fantastic sort of continuity of it, in that the patients who you're looking after you're seeing through their whole lives ... I find that very thrilling"	"I'm not happy about the practice that I'm in, in terms of the service that it offers to its patients. In the future I'd like to either change it ... or move to a different practice"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
68	British	Single	n/a	4 (adult)	"I had a trained nanny, I had two actually ... I had them both for quite a long time ... And then a succession of part-time helps ... I had domestic help as well when the children were small, I don't have them now, I do it myself now, I've done it myself for years"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"Always wanted to from when I was about 7 years old ... I remember that quite plainly"	15%	"I went to university with no science background at all ... it was difficult" "You were very much the poor relation ... unless you were very attractive and ... prepared to use your women's wiles a bit"	(1) GP (2) General surgery (3) Obs/gynae (4) Anaesthetics (5) GP	Obstetrics and gynaecology

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home	Good	Two receptionist/ nurses. Use of Social Worker, Midwife, Health Visitor, District Nurse	2,000+	Covers all her own on-call but has a reciprocal arrangement with other GPs for occasional cover.

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"If you want to be entirely domesticated then don't be a doctor ... do one or the other, you can't do both"	"It depends I think on how much the woman wants to do medicine"	"I've just enjoyed it ... general practice is something which you have to settle down to from the beginning ... in one place. I don't think to hop from place to place would ever give you any satisfaction at all in the end"	She wants to hand over her practice to her son when she retires.

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
49	Asian (India)	Married	Doctor - anaesthetist	3 (20, 18, 14)	"My husband helps me occasionally, not very much, but my mother-in-law is there ... between two ladies we can manage ... most of the time ... it is mainly my responsibility.

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors. Father - manager	"Right from the beginning I used to like ... nursing ... I was very good at science subjects ... and I used to like ... human biology ..."	15%	"I didn't have any problem"	(1) Medicine (2) Gynaecology (3) ENT (4) General surgery (tried Pt. II MS (failed)) (5) to UK after 8 years (6) community health (7) GP would have had to re-do general surgery in hospitals	Surgery

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Lock-up shop	Poor	Two receptionists (one for morning and one for evening surgery). Use of District Nurse, Midwife, Health Visitor.	2,400 (1,900 + 500 in branch surgery)	"(I use the deputising service) for the nights and weekends ... every night and weekends"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I would not like my daughter to do medicine ... because ... I don't do enough justice to the family ... I think there are advantages, and very few of my patients' husbands are registered with somebody else because they don't want a lady doctor"	"I think it depends upon the attitude ... if one wants to you can always work I think ... you could do a few sessions ... And later on you can work full-time"	"I get job satisfaction because there is always continuity of the job and I feel I'm doing something for people ... Sometimes I think I miss general surgery, which I wanted to do"	"I'll just continue in general practice, I quite enjoy it... I'll work as long as I can ... If the practice grows any bigger I'll have to take a partner"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
54	British	Separated (about to be divorced"	Doctor - GP	5 (3 adults, twins 17)	"It was my responsibility ... whether that's why I got a divorce now, I don't know, because I haven't had time to sort of be perhaps as good a housewife as I now regret I hadn't been ..."

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
Uncles	"My uncle ... was a pathological technician ... and the head-mistress said, well there's no need for her to stop at that. And so the idea was sewn really"	All women (1 man)	"I suppose I would have preferred to be not segregated, but on the other hand you felt very proud of being at perhaps the only university in the world that trained nothing but women"	(1) Obs/gynae (2) Community health (for 23 years) (3) GP	None

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
None	In Health Centre	Good	Two receptionists. Did have own practice nurse, but no longer ("cost too much"). Use of Health Visitor.	1800	"I'm thoroughly on-call all the time ... because the deputising service doesn't come out this far ... I've got an arrangement with my husband that he gives me every third weekend off"

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I think medicine isn't at all necessarily just for men, I mean women are just as able and just as capable and possibly more caring and more able to listen, and possibly from the patient's point of view, women for women and men for men maybe ..."	"I don't think really ... that it should be that women have to give up ... it so depends on the husband you marry ... not many men want to be mother ..."	"... the satisfaction is to be something which you feel is a rewarding job ... the disappointments are in a way the attitude of men ... men do think that your place is in the home and really why are you dabbling in all these things?"	"I'm going to stick at this and see whether it busts me or not"

BACKGROUND INFORMATION

AGE	ETHNIC ORIGIN	MARITAL STATUS	PARTNER'S PROFESSION	CHILDREN AND AGES	DOMESTIC ARRANGEMENTS
65	British	Married	Doctor - GP (Retired)	4 (adult)	"... surgeries would go on until 12 o'clock or after, and then I would come over here and have to start and see to lunch ... our big problem was the cooking ... you just can't get housekeepers to do that, I can't get anyone who'll do that for me"

MEDICAL TRAINING AND EXPERIENCE

FAMILY/PARENTS DOCTORS IN FAMILY	REASONS FOR DOING MEDICINE	WOMEN ON COURSE %	PROBLEMS/EXPERIENCES OF TRAINING	HOSPITAL EXPERIENCE	CHOICE OF SPECIALISM
No doctors	"I had an illness when I was 16½ ... I think I must have thought what an interesting profession it was. I plumped for medicine ... and that's how it all came about"	Not given	"There weren't any problems except at physics and physiology ... but the other things I just sailed through I had no problems at all."	(1) 2 hospital jobs - casualty (2) GP - difficulty getting hospital jobs	GP

GENERAL PRACTICE PAST AND PRESENT

PREVIOUS GENERAL PRACTICE	PRESENT PRACTICE PREMISES - LOCATION	QUALITY OF PREMISES	USE OF ANCILLIARY/ COMMUNITY STAFF	LIST SIZE	OUT-OF-HOURS COVER
In partnership	Attached to home	Good	One receptionist. Use of District Nurse, Health Visitor, Midwife	1,050	Not given

ATTITUDES AND ASPIRATIONS

PROS AND CONS FOR WOMEN IN MEDICINE	WASTAGE	SATISFACTIONS AND DISAPPOINTMENTS	AMBITIONS/ASPIRATIONS THE FUTURE
"I always advise young women doctors to take some years off to look after their family ... because I don't think there's any substitute for a mum"	No comment given	No comment given	"I think I'll retire at 70"

APPENDIX D

Paying the Professions

This is taken from Appendix 2 of 'Primary Health Care: an Agenda for Discussion' 1986, Cmnd. 977. London, HMSO, pp 56-58 and describes how doctors in the family practitioner services are paid.

Aston University

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