TALKING POINT

Training and careers of women doctors in the Thames regions*

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Fifteen years ago, the first surveys of women doctors in Britain[1 2] drew attention to the fact that, while many were happily and actively engaged in medical work, a proportion were facing difficulties and disappointments in their careers. There have been many changes in the Health Service since then, but there has been little statistically sound evidence to suggest that the position for women in medicine has improved. This survey has updated our knowledge of the families and careers of women doctors, with particular reference to the extent of, and reasons for, dissatisfaction.

Method

A questionnaire was sent to all women doctors with registered addresses in three Thames regions in the 1975 *Medical Register* and subsequent fortnightly lists who first registered between 1945 and 1974. An accompanying letter was sent from the Medical Women's Federation. There were two reminders and a 10% sample of non-respondents were followed up by telephone to ascertain the reasons for non-response.

Between February and May 1976 2433 completed questionnaires were returned, giving a usable response rate of 75%. More of those who replied had qualified in the UK or qualified before 1960 (or both) than of those who did not. Tests of significance used in the analysis were the test for the standard error of differences between two proportions and the χ^2 test. Results were significant at the 5% level unless otherwise specified.

Results

CHARACTERISTICS OF RESPONDENTS

Of the 2433 respondents 80% were graduates of British medical schools. Of those who qualified overseas 87% were from new Commonwealth countries. New Commonwealth graduates formed a higher proportion of the total in the younger age groups. Trends in marriage patterns are summarised in table I. Of the married respondents 22% had no children, 16·5% had one child, 31% had two, and the remainder three or more. Twenty-eight per cent had at least one child under 5 and 46% had at least one child aged between 5 and 16. Ten per cent of respondents had someone other than a child dependent on them. Over half of these also had responsibility for children. The commonest age at qualification was 24. The mean and median age at qualification has been falling recently. A higher medical qualification was held by 58% of respondents and 22% held more than one. Single women were more likely to hold one or more qualifications. The commonest higher degree was the DRCOG followed by the DCH, MRCP, and DA.

*This survey's findings were presented for the MSc examination in social medicine at London University.

EMPLOYMENT

The relationship between current employment and marital status is shown in table II. Ninety-one per cent of single women working were in full-time posts, compared with 83% of childless married women, and 40% of married women with children ($P < 0·01$).

The type of work undertaken is shown in table III. In the hospital service, older women with children were more likely to be in medical assistant than consultant posts, though at senior registrar level women of differing marital status were proportionately represented. The commonest hospital specialties at whatever grade were anaesthetics (17·4%), psychiatry (15·4%), paediatrics (10·4%), medicine (10·2%), and obstetrics and gynaecology (9·4%).

Of the part timers 66% were working five or more sessions a week, 21% three or four sessions, and 13% were working only one or two. Eighty-seven per cent of all part timers were working regular sessions and were more likely to be doing so the more sessions they worked. Twenty-nine per cent wished to take on further sessions: 66% of these said that suitable jobs were not available and 23% mentioned lack of adequate child care facilities as a problem preventing them from taking on more work.

Of the 213 respondents not currently employed in medical work 74% were married women with children. Nineteen per cent of women with at least one child under five were not working, compared with 6% of those with only children over 5 ($P < 0·01$). Reasons given for not working are shown in table IV. Of the 770 respondents who had given up work to care for children or other dependents 22% said that they had chosen to do this rather than working. Eighty-two per cent of unemployed respondents intended to return to medical work at some time.

Seventeen per cent of respondents were not able to train and/or work in their preferred specialty. Twenty-three per cent of women with children expressed dissatisfaction with their specialty compared with 9% of women without ($P < 0·01$). Fifty-four per cent of those not in their preferred specialty thought that domestic responsibilities had limited their choice, 33% said that there had been no suitable training facilities, and 20% thought that they had been discriminated against on grounds of sex.

PROBLEMS IN CAREER

Only 4% did not believe that there were career problems for women in medicine. Twenty-four per cent thought there were difficulties only for married women, and a further 21% specified only married women with children. When asked about problems in their own career, 40% thought that they had not encountered difficulties. Even so, 13% of this minority specified that this was because they had been lucky, and a further 15% expected to meet problems in the future. A significantly higher proportion of those who had not experienced problems were childless and had qualified within the past six years.

TABLE I—*Trends in marriage*

Year of birth	No in age group	% married	% married with doctor husbands	Age by which 50% married	% married by year of graduation	% women* in population married (1973)
1920–4	279	78·5	42·5	28½	22·9	92·3
1925–9	366	80·3	47·3	27½	20·8	92·6
1930–4	329	83·9	47·5	27	23·3	93·2
1935–9	354	86·7	48·9	26	28·5	93·5
1940–4	427	83·4	48·6	25¾	29·0	92·4
1945–9	475	73·9	54·1	25½	34·4	87·0
1950–2	118	50·0	59·3	26	29·5	59·4
All years	2433	78·9	48·5			

*Registrar General's Statistical Review 1973.

TABLE II—*Employment and marital status (UK)*

Employment status	Single No (%)	Married No (%)	Married + children No (%)	All (100%)
Full time	428 (35)	331 (26)	535 (41)	1294
(%)	(85)	(78)	(36)	(54)
Part time	45 (5)	67 (7)	790 (88)	902
(%)	(9)	(16)	(53)	(37)
Unemployed	30 (14)	26 (12)	157 (74)	213
(%)	(6)	(6)	(11)	(9)
Total (100%)	503 (21)	424 (17·5)	1482 (61·5)	2409

TABLE III—*Current employment of respondents*

Post held	Single No (%)	Married No (%)	Married + children No (%)	All (100%)	In post part time %	All employed doctors in post %
Hospital:						
Consultant	95 (38)	44 (17)	115 (45)	254	39	11·6
Medical assistant	20 (26)	6 (8)	52 (66)	78	49	3·6
Senior registrar	25 (25)	23 (23)	51 (50)	99	17	4·5
Clinical assistant	24 (9)	27 (10)	219 (81)	270	80	12·3
Other	165 (38)	146 (33)	128 (29)	439	10·3	19·9
Total in hospital	329 (29)	246 (22)	565 (50)	1140	38	51·9
General practice:						
Principal	85 (19)	66 (15)	294 (66)	445	21	20·3
Assistant	4 (4)	11 (10)	92 (86)	107	88	4·9
Total in general practice	113 (16)	111 (16)	479 (68)	703	40	32·0
Community health:						
Clinical	27 (5)	41 (8)	442 (87)	510	68	23·2
Other (including community medicine)	16 (22)	8 (11)	48 (67)	72	11	3·3
Total	43 (7)	49 (9)	490 (84)	582	58	26·5
Other medical employment	34 (23)	27 (18)	90 (59)	151	45	6·9
All employed respondents	473 (22)	398 (18)	1325 (60)	2196 (100)	41	2196 (100)

TABLE IV—*Reasons for unemployment among respondents*

Reason	Currently unemployed No (%)	Any unemployment in the past 15 years No (%)
Domestic responsibilities	130 (59·4)	770 (71·9)
No suitable part-time posts	60 (27·4)	380 (35·5)
Marriage situation	28 (12·8)	161 (15·0)
Financially not worthwhile	26 (11·9)	84 (7·8)
No suitable full-time posts	25 (11·4)	136 (12·7)
Lack of training facilities	24 (11·0)	104 (9·7)
In alternative non-medical work	24 (11·0)	59 (5·5)
Own ill health	22 (10·0)	122 (11·4)
Unable to obtain a job	6 (2·7)	26 (2·4)
Retired	5 (2·3)	6 (0·6)
Studying	4 (1·8)	43 (4·0)
Long holiday	2 (0·9)	52 (4·9)
Other reasons	11 (5·0)	15 (1·4)
Number answering†	219 (100·0)	1071 (100·0)

*"Unemployment" constituted a period of three months or longer out of medical work.
†Respondents may have mentioned more than one reason.

TABLE V—*Current employment by years since qualification*

Years since qualification	Year of survey	% working	% of those working in full-time work	% unemployed	Total in group
2–6	1962*	78	73	22	1261
	1966†	84	73	16	251
	1976§	89	83	11	495
7–11	1962	77	53	24	1299
	1966	81	57	19	227
	1976	89	53	11	464
12–16	1962	79	51	21	1570
	1966	86	55	14	294
	1976	90	49	10	388
17–21	1962	83	52	17	1120
	1966	86	59	14	283
	1976	94	51	6	347
22–26	1962	88	53	12	881
	1976	94	56	6	383
27–31	1962	90	62	10	564
	1976	92	63	8	301

Sources: *Survey of 8209 women doctors resident in UK, conducted by Medical Practitioners Union. Published as *Women in Medicine*, Office of Health Economics, 1966. †Survey of 1055 women graduates of the Royal Free Hospital Medical School, *British Journal of Medical Education*, 1969, **3**, 28. §Present survey.

Discussion

The results suggest that the professional commitment made by women doctors has increased over the past 15 years. Comparisons can be made with findings from earlier surveys (see table V). The percentage of trained doctors in every qualification group who were not working in 1976 was significantly lower than percentages in previous studies ($P < 0.01$). As has been shown in the past,[1-7] most women doctors not working regarded their unemployment as a temporary phenomenom. A higher proportion of part timers in 1976 were in regular work of more than five sessions a week, with almost a third wishing to take on more sessions. Together with the picture of lower medical unemployment, this suggests that women doctors are now devoting a higher proportion of their post-qualification years to active medical work. This is all the more encouraging in view of the increased proportion of women doctors marrying compared with 1962.[2] Since then increasing proportions of women have gained higher qualifications, from 46% in 1962-4[1 2] to 54% in 1969[3] and 58% in this study. Specialty distribution has remained broadly similar.

Despite the evident contentment of many respondents with their choice of career, there were indications that women doctors in 1961 and 1976 faced similar difficulties. Examples of discrimination against women on grounds of sex were quoted by unmarried respondents in such areas as specialty choice (particularly in surgical fields), "living in" hospital accommodation, and general practice opportunities. This suggests that the commonly expressed view that sex discrimination against women no longer exists[8 9] is over-optimistic.

Marriage caused difficulties for some women. Married women reported opposition to the idea of their working from selection committees, colleagues, and occasionally even husbands. Wives also thought that they had sacrificed their own career hopes for their husbands'. Childless married women were less likely than their single contemporaries to be working full time, to work in the hospital service, or to hold higher qualifications. Since women doctors are now more likely to be married by qualification year than in the past[2-4 6] more women doctors will be embarking on their medical career already married, and married women will form an increasing proportion of trained doctors.

Women with children were the most disadvantaged group, as previous surveys have suggested.[1-3 6 8 10 11] The practical problems were summed up by a principal in general practice: "One has to have a co-operative husband, undemanding children, reliable help at home, limitless mental and physical energy, and enormous determination." Many instances were quoted of difficulties in obtaining part-time training and work, suitable alternative child care facilities, and adequate remuneration. Mothers working also reported disapproval and distrust from Health Service colleagues who implied that their commitment and reliability must be less than a man's. A sizeable minority expressed opinions about the conflict between job and family which they thought working mothers faced, and which did not seem to be understood by their colleagues. Though the proportion of women doctors having at least one child does not appear to be on the increase, the total number of women doctors with children is rising as numbers of women in the profession rise. So the implica-

Medical dispute in Malta

On 19 November 1977 (p 1368) we published a report by the president of the World Medical Association, Dr P A Farrelly, and the chairman of the WMA Council, Mr Walpole Lewin, after their visit to Malta to try to settle the medical dispute on the island. The republic's Minister of Health, Dr V Moran, has replied to the report. We publish his letter here together with two draft letters from the president of the Medical Association of Malta, Dr F G Callus, the first of which was drafted by the MAM and the second by the Maltese Government.

Dr Farrelly and Mr Lewin, who had referred to the draft letters in their report, were invited to comment on Dr Moran's reply and we also publish their views.

Minister's letter

The report on the medical dispute in Malta by the president of the World Medical Association, Dr P A Farrelly, and the chairman of the WMA Council, Mr Walpole Lewin (19 November 1977, p 1368), contains statements which must be corrected or clarified in order that your readers may be given the full picture of the situation.

The report speaks of "limitations of medical services to the people of Malta, the interruption of studies of the medical students, and the fact that many doctors whose services are surely needed are not in practice." While it is true that initial difficulties had to be overcome, the medical services provided to the people of Malta even at the time of the visit to Malta of Dr Farrelly and Mr Lewin were at least of the same standard as those provided before the dispute started, and they have since improved even further. The interruption of the studies of the medical students, apart from being limited to fourth-year students, was the result of a decision taken by them to boycott the reopening of the medical school and to accept assisted tuition in Britain arranged for them by the MAM in co-operation with the BMA. All second-year students and 12 fourth-year students are now attending regularly the medical schools in Malta. So could the other fourth-year students if they so wished.

The other statements that call for correction and for additional information refer to the draft letter indicating the so called "preparedness of the MAM to suspend its sanctions on the basis of the talks that had taken place and to begin formal negotiations."

This letter was not, as stated in the report by the WMA officials, sent to the Government; nor were the WMA officials "invited to be present when the draft was presented to the Government officials." The draft was brought to me in the presence of my advisers by Dr Farrelly and Mr Lewin, and we were asked whether it could elicit a favourable response from the Government.

The response of the Government was that reported by the WMA officials with, however, certain important omissions. The response in fact was that: "The Government was unable to accept the draft and explained that there were . . . words and phrases which indicated that no real progress had in effect been made." As stated in the report, the Government gave to the WMA officials the alternative "words and phrases" which truly reflected the clarifications given by the Government. I am reproducing the two draft letters, italicising the parts where they differ, to enable your readers to judge whether the differences were of real substance or merely carried imaginary interpretations as Dr Farrelly and Mr Lewin have suggested. The following is the text of the two drafts:

Letter drafted by Medical Association of Malta

The Medical Association of Malta has noted the *assurances given* by the Government of Malta through the officials of the World Medical Association. The MAM has been informed that during the discussions to follow the lifting of all its directives, no new medical appointments will be made *until* negotiations *have been finalised* and that *all* hospital doctors affected by this dispute will be treated as a group *in reaching agreement on the date for resumption of duties.*

The WMA officials have also informed the MAM of the Government's interpretation of the relevant laws enacted since May 1977, *of its readiness to review the legislation affecting the medical profession* and of its intentions with regard to the health services.

On the basis of these *assurances* and this information, the committee of the Medical Association of Malta has decided to recommend to an extraordinary general meeting of its members the lifting of all its directives relating to this dispute with a view to starting immediate negotiations with the Government on all matters affecting the medical profession and the proposed health scheme.

The Medical Association of Malta is confident that with goodwill on both sides a satisfactory solution to all the problems can be achieved to avoid the prolongation of the dispute.

Letter drafted by Government of Malta

The Medical Association of Malta has noted the *clarifications made* by the Government of Malta through the officials of the World Medical Association. The MAM has been informed that during the discussions to follow the lifting of all its directives, no new medical appointments will be made *while the* negotiations *are taking place* and that *in the negotiations covering* the hospital doctors affected by this dispute they will be treated as a group.

The WMA officials have also informed the MAM of the Government's interpretation of the relevant laws enacted since May 1977, of its intentions with regard to the health services, *and to the future legislation affecting the medical profession.*

On the basis of these *clarifications* and this information, the committee of the Medical Association of Malta has decided to recommend to an extraordinary general meeting of its members the lifting of all its directives relating to this dispute with a view to starting immediate negotiations with the Government on all matters affecting the medical profession and the proposed health scheme.

The Medical Association of Malta is confident that with goodwill on both sides a satisfactory solution to all the problems can be achieved to avoid the prolongation of the dispute.

To these texts I may add the following comment. If the words and phrases objected to by the Government had not been intended to convey the meaning "read into them" by the Government, surely the MAM would not have objected to changing them to remove such a possible interpretation.

The texts reproduced above show three main differences. The first difference was whether the Government had given any assurances or had merely agreed to make clarifications. That the Government's view concerning this difference was the correct one is confirmed by the WMA's report, which says: "It was finally agreed that these should be *clarification* talks between the two sides."

The second main difference referred to the position of dismissed doctors. In the talks held with the WMA officials it was made abundantly clear that there could be no question of dismissed doctors "resuming" duties. They could be offered a fresh appointment, but not a continuation of the one that had been terminated. In confirmation of this I can quote from the agreed and signed minutes of the meetings held with the WMA officials: "Dr Moran replied that those doctors who were still in Government employment would under such circumstances be

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tions for the Health Service of employing women doctors with children will not diminish.

Current attitudes and practices are still a barrier to women doctors achieving professional fulfilment. Attempts made to overcome difficulties have not been completely successful. This will be illustrated in a further report of this survey. A century ago, a woman doctor wrote: "But, aided or unaided, the day is not far distant when women will compel medical men to know that as physicians they are their equals, whether they have the magnanimity to acknowledge it or not."[12] The time for acknowledgment has come, not just with words but with deeds. Not only our medical colleagues but those responsible for the finance and organisation of the Health Service must recognise, and act on, the need for urgent changes. Only by doing so will the professional frustration of women doctors and the underutilisation of valuable medical womanpower be remedied.

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