Part-time women general practitioners — workload and remuneration

JUDITH HOOPER

JILL MILLAR

PENNY SCHOFIELD

GILLIAN WARD

SUMMARY. A postal questionnaire survey was conducted comparing the workload and remuneration of part-time women principals in group practices in the Northern and Oxford regions. Part time was defined as receiving less than a full profit share at parity. Of 501 women principals 308 (62%) responded of whom 146 (47%) were part-time. Respondents were asked to record aspects of workload over a four-week period for themselves and their full-time partner who did the most sessions within the practice. The results showed that although two-thirds of the part-timers had 50% or less of a full profit share, part-time principals overall did about 76% of the daytime clinical work (surgeries and home visits) done by their full-time partners, excluding specialized clinics. The lower the profit share the wider this discrepancy. Although 33% of the respondents did no out-of-hours work, the remainder did more than their profit share would indicate. Twenty per cent of the 116 principals with 40% or more of a full profit share and 57% of the 30 principals with less than 40% of a full profit share felt that their share was unfair. Lack of involvement in practice business and feeling that opinions did not carry equal weight were associated with feelings of unfairness.

Introduction

IN its white paper *Promoting better health*[1] the government has agreed to discuss with the profession what arrangements might be made to ensure that more women are encouraged to enter, and remain, in general practice. The proposals include the development of opportunities for job sharing and part-time working.

Some women doctors feel that part-time work gives the best opportunity to combine a career with having a family.[2] However, not all women wish to work part time. A recent survey of former general practitioner trainees[3] showed that although 58% of women originally wanted full-time partnerships, only 36% achieved this. Many of these women, in the course of applying for partnerships, felt pressurized to alter their objectives and take part-time posts.

Advertising a part-time partnership is usually seen as a covert way of attracting women applicants. Hearsay evidence, at least, suggests a disparity between workload and remuneration in a number of these posts. In a survey looking at why some women chose single-handed practice, Lawrence[4] noted that when working in group practices 'women general practitioners felt they had to shoulder the greatest burden of work for the least reward'.

Previous surveys[5,6] have compared the workload of men and women general practitioners without reference to their status and remuneration. Lack of such information, that is how many have a less than full profit share, means that it is difficult to make a useful comparison. The aim of this investigation was to identify part-time women principals and compare their workload with the partner who did the most sessions within their practice.

Method

The method has been described in more detail in a previous paper.[7] A postal questionnaire was sent to all women principals in the Northern and Oxford regions, asking them to indicate whether they were full time (full profit share at parity), part time (less than full share at parity) or salaried. Also recorded were qualifications, sex and status of other doctors in the practice, the practice list size, partnership agreements and maternity leave arrangements.

Respondents receiving less than a full profit share were divided into two groups as follows: minimum share partners (those with less than 40% of a full profit share) and moderate share partners (those with 40% or more of a full profit share). This division was chosen as it enabled closer scrutiny of those with a partnership share near the legal minimum of one third of a maximum share, as defined by partnership law.[8]

Workload was determined by recording over a four-week period the time spent in surgeries and in specialized clinics, number of visits and share of out-of-hours commitment. In all cases the respondent recorded the same data for the full-time partner, irrespective of sex, who did the most sessions in the practice (referred to afterwards, as the 'full-time partner'). Questions were also asked about practice business. The percentage share of partnership profits, time taken to reach parity and share in practice property, were recorded for the respondent and her full-time partner. Finally the respondents were asked: 'In your view is the practice income shared fairly between partners?' They were also asked for any comments.

The data were analysed using the SPSSX package.

Results

Of the 2815 principals in the two regions 501 (18%) were women. After the second reminder 308 (62%) had replied, of whom 146 (47%) were part time and working in group practices. Nearly half (49%) of all part-time respondents had been principals for less than five years and 46% were in training practices.

One hundred and sixteen respondents (79%) were 'moderate share partners', with 40% or more of a full profit share, and 30 respondents (21%) were 'minimum share partners' with a less than 40% share; one respondent's 20% share was illegal.[8] Nearly two-thirds of part-timers (64%) had 50% or less of a full profit share. For the moderate share part-timers the mean profit share was 58%, for the minimum share group it was 34%. Fourteen (47%) of the minimum share partners were in training practices.

Half of both the minimum share and moderate share groups had attained parity within one year, but 36% of both groups took two years or more to do so.

J. Hooper, MRCGP, lecturer in primary health care, University of Newcastle upon Tyne; J. Millar, MRCGP, P. Schofield, MRCGP, A.G. Ward, MRCGP, general practitioners, Newcastle upon Tyne.

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Workload

Daytime. The mean number of surgeries done by respondents was 72% of that done by their full-time partners, irrespective of profit share (Table 1). The mean number of visits made by minimum share partners was 78% of that made by their full-time partners, and was 68% for the moderate share partners. Table 2 shows the total surgery time and number of visits expressed as a ratio of each part-time respondent with her full-time partner. Overall, part-time principals did about 76% of a full daytime clinical workload regardless of their profit share. The lower the profit share, the worse the discrepancy was.

For those practices that did specialized clinics (Table 3), for example antenatal, well-woman or well-baby clinics, more of the moderate share partners did these clinics than their full-time partners, especially in the case of well-woman clinics. Item of service fees, attracted by these clinics, were paid to the practice in nearly 90% of cases, and not to the individual principal.

Out of hours. Table 4 shows the proportion of principals who did out-of-hours work. Although one-third of part-timers were not on call, the remaining two-thirds did more on-call duties than their profit share would indicate.

Out-of-hours commitment was further analysed by dividing it into weekday nights and weekends, comparing each respondent directly with her own full-time partner (Table 5). Of the respondents who did out-of-hours work, the ratio of number of nights done by the minimum share partners to that of their full-time partners was 0.48 and for the weekends 0.63; the moderate share partners did 73–79% of a full share of on call. The ratio of number of nights and weekends using a deputy was 0.83–0.88 for both minimum and moderate share respondents.

Practice administration

One hundred and twenty part-time respondents (82%) had written partnership agreements and 81 of these (68%) had maternity clauses. The presence of another woman in the partnership, particularly a part-timer, more than doubled the likelihood of having a maternity clause.

One hundred and thirty three respondents were in practices which had meetings and all the part-timers attended them. Excluding the 34 practices where there was no chairperson, all full-time men partners could chair meetings whereas only two-thirds (64%) of part-time women could take the chair.

Nineteen respondents (14%) felt unable to express their opinions in meetings; six of these had been principals for more than five years. Thirty women (23%) felt their opinions did not carry much weight, nine of whom had been principals for more than five years. Of the 69 part-timers in Oxford who had meetings 13% felt unable to express their opinion in practice meetings compared with 8% of the 64 part-timers in the Northern region who had meetings, and 28% of these part-time Oxford doctors felt that their opinion did not carry equal weight with that of their men partners compared with 16% in the north.

Sixteen (11%) respondents were excluded from financial decisions and a similar proportion were unable to see the accountant, with 25 (17%) being unable to sign cheques. Four respondents were denied access to the practice accounts, which negates their status as partners under partnership law.[8]

Table 2. Mean ratio of workload between each part-time respondent and her full-time partner.

Percentage of full profit share	*n*	Mean (SD) ratio[a] Total time in surgery per 4 weeks	Number of visits per 4 weeks
<39	28	0.80 (0.37)	0.78 (0.26)
40–49	12	0.70 (0.17)	0.64 (0.23)
50–59	37	0.83 (0.52)	0.73 (0.34)
60–69	14	0.74 (0.12)	0.80 (0.60)
70–79	8	0.74 (0.15)	0.93 (0.39)
80–89	5	1.19 (0.35)	0.97 (0.84)
90–99	4	0.95 (0.23)	0.80 (0.22)

[a]Ratio of values for each part-time respondent with those of her full-time partner. SD = standard deviation. *n* = number of comparisons.

Table 3. Specialized clinics taken by part-time principals and their full-time partners.

	Type of specialized clinic		
	Baby	Antenatal	Well-woman
Number (%) of GPs taking clinics			
Minimum share respondents (*n* = 30)	12 (*40*)	16 (*53*)	8 (*27*)
Full-time partners (*n* = 30)	12 (*40*)	17 (*57*)	1 (*3*)
Moderate share respondents (*n* = 116)	62 (*53*)	72 (*62*)	37 (*32*)
Full-time partners (*n* = 116)	35 (*30*)	58 (*50*)	6 (*5*)
Mean (SD) number of clinics per 4 weeks			
Minimum share respondents (*n* = 30)	2.6 (1.5)	3.4 (1.8)	4.0 (2.8)
Full-time partners (*n* = 30)	2.5 (1.2)	3.4 (1.7)	1.0 (0.0)
Moderate share respondents (*n* = 116)	2.1 (1.3)	3.0 (1.3)	3.0 (1.3)
Full-time partners (*n* = 116)	2.0 (1.2)	3.2 (1.1)	3.2 (2.8)

SD = standard deviation.

Table 1. Mean daytime workload analysis of part-time women principals in comparison with their full-time partners.

	Mean (SD) number of surgeries per 4 weeks	Mean (SD) intended length of surgeries (hours)	Mean (SD) actual length of surgeries (hours)	Mean (SD) total time in surgery (hours per 4 weeks)	Mean (SD) number of visits per 4 weeks
Minimum share respondents (*n* = 30)	21.0 (4.64)	1.8 (0.40)	2.3 (0.49)	48.3 (15.9)	76.0 (45.6)
Full-time partners (*n* = 30)	30.3 (7.94)	1.8 (0.39)	2.1 (0.59)	63.6 (19.2)	97.0 (53.4)
Moderate share respondents (*n* = 116)	21.6 (5.07)	1.9 (0.46)	2.3 (0.49)	49.7 (14.9)	52.0 (29.0)
Full-time partners (*n* = 116)	31.0 (6.13)	1.8 (0.55)	2.2 (0.57)	68.2 (18.6)	77.0 (36.0)

SD = standard deviation.

Table 4. Out-of-hours commitments of the women principals and their full-time partners.

	Number (%) of respondents who do out-of-hours work/ number answering	
	Weekday nights	Weekends
Minimum share respondents	13/27 (*48*)	13/27 (*48*)
Full-time partners	23/27 (*85*)	24/27 (*89*)
Moderate share respondents	58/84 (*69*)	48/87 (*55*)
Full-time partners	74/84 (*88*)	75/87 (*86*)

Sixty four respondents (44%), nine being minimum share partners, had a share in their practice property and this share correlated approximately with their profit share. However, 20 respondents had no property share, despite the property being owned by more than one other partner; this applied to 22 of the minimum share partners (73%) and 57 of the moderate share partners (49%).

Payment of the vocational training allowance and seniority awards, when applicable, were paid as often to the practice as to the individual, except for minimum share partners where one in three respondents paid it into the practice.

Factors associated with discontent

Twenty three (20%) of the 116 moderate share and 17 (57%) of the 30 minimum share partners felt that their profit share was unfair. Cross-tabulation of responses to this question with the other questions showed that factors associated with feelings of unfairness were: higher proportion of total surgery time than their profit share; higher proportion of visits than their profit share; lack of maternity agreement; lack of practice meetings; lack of involvement with financial decisions; inability to express opinion in practice meetings; opinion not felt to carry equal weight in practice meetings.

Comments

One woman commented: 'I realize the workload/remuneration ratio is not ideal but I can't see any way to change it if I want the job'. The respondents often commented that they felt that a positive attitude towards them by their men partners was important and that this could compensate for the profit share/workload disparity. A number of respondents commented that they had changed practices recently because of dissatisfaction and inability to produce change, and had the questionnaire applied to their previous practices they would have described a far worse scenario.

Discussion

Most women doctors continue to work, either full or part time, despite the conflicts between their career and their family.[9]

Our results show that, overall, part-time principals have three-quarters of a full daytime clinical workload, that is surgeries and visits, as well as taking at least an equal number of specialized clinics. This compares with two thirds of respondents having profit shares of 50% or less. Out-of-hours workload is often cited as the equalizing factor in this equation; however the doctors and dentists' review body report[10] priced out-of-hours work at only 13.5% of gross remuneration. In practices which covered their own out-of-hours duties, we showed that although one third of part-timers were not on call, the remainder did more on call than their profit share would indicate.

The frequent criticism of part-time partners that they are not motivated or available to be involved with the practice business is not supported. In our study exclusion from practice business contributed to feelings of discontent about profit shares among part-time women principals. All part-time women attended practice meetings (where they existed) but over a quarter felt a lack of status in discussion and decision making. As a third of these had been principals for more than five years their part-time status may be a relevant factor.

The independent contractor status of general practitioners and the minimum of 20 hours per week spent on general medical services gives flexibility within contractual arrangements. All principals in receipt of a full basic practice allowance have the same contract with their family practitioner committee. However, within each practice, working arrangements can vary enormously and still fulfil this commitment. It is this flexibility which has allowed the existence of part-time posts in general practice, yet paradoxically it is this flexibility which permits the exploitation of part-time posts in general practice. Other partners can take on professional outside commitments such as committee work, clinical assistantships and teaching, which form a necessary part of general practice in the UK, yet do less work within the practice than their part-time partners, and still fulfil their family practitioner committee contract.

Conclusions

There is clearly a discrepancy between profit share and workload for many part-time principals. Both full-time and part-time general practitioners should recognize this and negotiate fair contracts. When general practitioners are applying for, or offering, a part-time partnership it is worth considering the following points:

1. Profit shares of less than 40% of an average full share are paid for entirely by the allowances for being a principal (that is basic practice allowance and so on), irrespective of per capita, item of service fees or other income.
2. To qualify as a principal there is a minimum limit of 20 hours per week spent in general medical services. Can profit shares of less than 50% be justified by the full-time partners?
3. If item of service fees, attracted by specialized clinics, are paid into the practice then the individual doing such clinics can expect no benefit from this income if their profit share is less than 40%.

Table 5. Mean ratio of on-call commitments and use of a deputizing service between each part-time respondent and her full-time partner.

	Mean (SD) ratio[a]			
	Weekday nights on-call	Weekends on-call	Weekday nights using deputy	Weekends using deputy
Minimum share respondent[b]	0.48 (0.31)	0.63 (0.26)	0.83 (0.29)	0.88 (0.25)
Moderate share respondents[c]	0.79 (0.43)	0.73 (0.27)	0.86 (0.25)	0.86 (0.21)

[a]Ratio of values for each part-time respondent with those of her full-time partner. [b]Number of respondents doing on-call: 13 (nights), 13 (weekends); number using a deputy: 3 (nights), 4 (weekends). [c]Number of respondents doing on-call: 58 (nights), 48 (weekends); number using a deputy: 12 (nights), 12 (weekends). SD = standard deviation.

4. Part-timers do as many specialized clinics as full-timers (and more well-woman clinics) and this should be allowed for in calculating the total daytime clinical workload.
5. Virtually all part-time partners have a higher daytime clinical workload relative to their profit share. The lower the profit share the higher the discrepancy.
6. Training practices have the same proportion of minimum share partners as other practices.
7. Although some part-timers opt out of on-call duties there is a considerable discrepancy between out-of-hours workload and profit share for part-timers.
8. Full involvement with practice business is important to the status of part-timers.

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Address for correspondence

Dr J. Hooper, Division of Primary Care, University of Newcastle upon Tyne, Medical School, Framlington Place, Newcastle upon Tyne NE2 4HH.

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