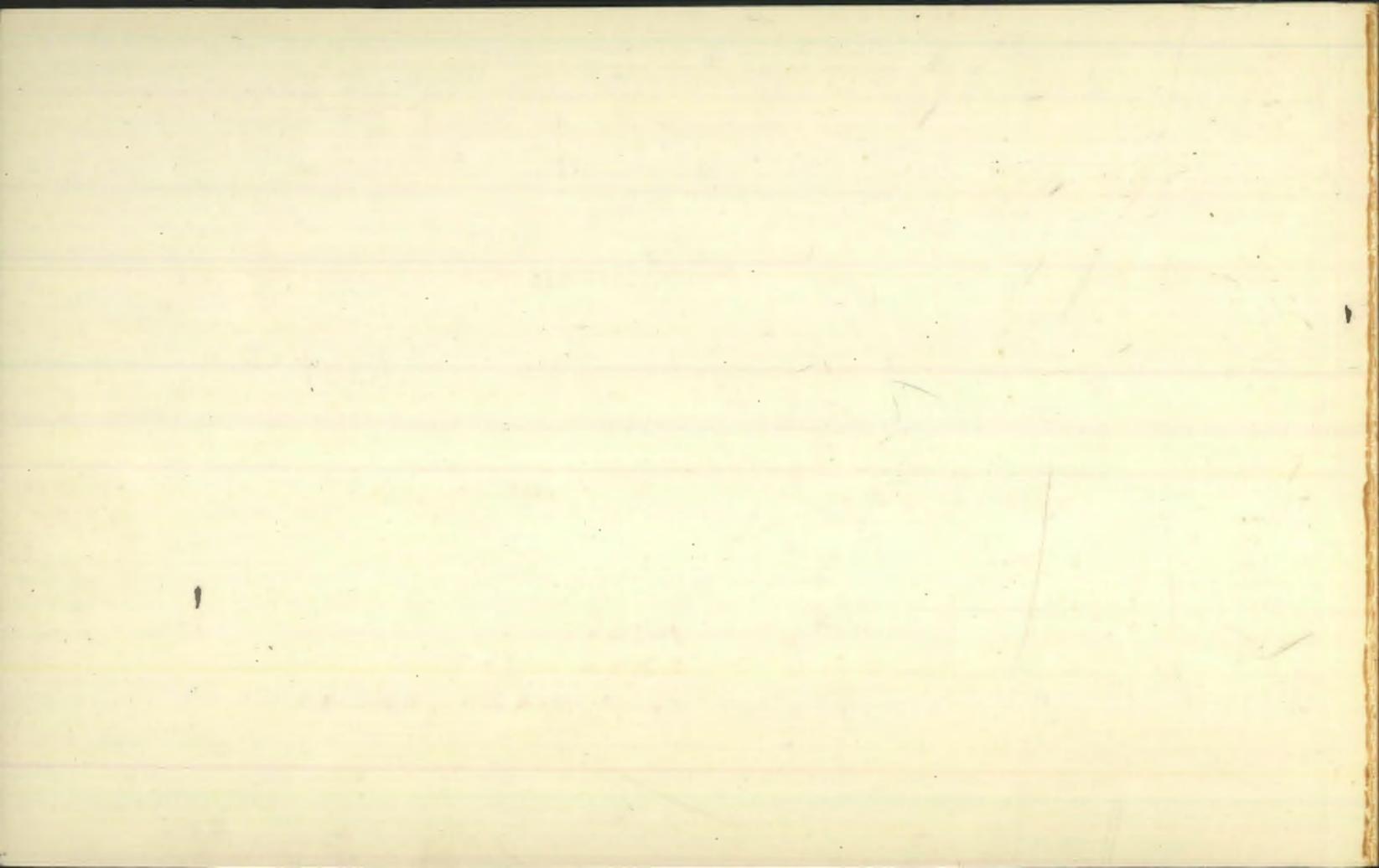


# Women in Medicine

The results of an inquiry  
conducted by the  
Medical Practitioners' Union in 1962-63

*Published by*  
Office of Health Economics  
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Prepared for publication and for the  
Royal Commission on Medical Education

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Women in  
Medicine

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It is the intention of the Medical Practitioners' Union and the Office of Health Economics to publish this book as a contribution to the study of the position of women in the medical profession. The book is intended to be a starting point for discussion and research. It is not intended to be a definitive statement on the subject.

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Certain individuals, however, must be named. It is no exaggeration to say that the report owes most to Dr E. R. Bransby, of the Ministry of Health who supervised the coding, analysis and tabulation of the data and who commented critically and constructively on the text of the report.

We are also grateful to Dr J. H. F. Brotherston, Dr Anne Bolton and Dr Jean Lawrie for advice in the initial stages of the inquiry; to Mr B. Stanton, Editor of the Medical Directory, for help in identifying those to be included in the study; to Mr Walter Davis of the Medical Practitioners' Union for assistance in handling the data; and to Dr Joyce Leeson, Dr Muriel Newhouse and Dr E. A. Smith for reading and commenting on the report in draft form.

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## INTRODUCTION

A shortage of doctors and the impossibility of expanding basic training facilities sufficiently to close in the immediate future the gap between supply and demand have focused attention on the use made of those who have already qualified in medicine. Where men are concerned, attention has been directed mainly to measuring the effect of emigration and immigration on the number of doctors practising in this country.<sup>1</sup> With women, interest has centred on the effect of marriage and maternity on the proportion of qualified women doctors practising their profession at any given moment of time and on the extent to which their post-qualification years are spent in active practice;<sup>2</sup> but data concerning the marital status of women doctors have hitherto been limited or lacking. It is on these aspects of the problem of efficient use of medically qualified personnel that the inquiry conducted by the Medical Practitioners' Union in 1962-63 has new light to shed.

In this paper, after describing the data and the method used to obtain them, we consider

- 1 the relationship between the age, marital and maternal status, place of residence and qualifications of women doctors living in this country and their work,
- 2 the obstacles to employing them on a full- or part-time basis in the health services,
- 3 the trends in marriage rates, age of marriage and maternity of women doctors,
- 4 the implication of these findings for the future employment of women doctors.

<sup>1</sup> cf. Brian Abel-Smith and Kathleen Gales (1964), 'British Doctors at Home and Abroad'.  
<sup>2</sup> cf. Lawrie, J., Newhouse, M. L. and Elliott, P. M. (1966), *British Medical Journal*, 1, 409.  
Lunn, J. E. (1964), *Medical Care*, 2, 197.  
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## THE DATA

In 1962, the MPU decided to obtain information about the marital status, family responsibilities and work experience of women doctors resident in the United Kingdom who had not permanently retired from work on account of age. After considering alternative ways of reaching such women, it was decided to use the Medical Directory and the annual lists of new registrations maintained by the General Medical Council.

Between July and December, 1962, question forms were sent by post to women whose names were listed in the Medical Directory for 1960 and to those whose names appeared on the new registration lists for 1960, 1961 and 1962. They were not sent to those who were marked as retired in the Directory nor to those with addresses outside the United Kingdom. In the first six months of 1963, those who had failed to reply were written to again and in September a third request went out, together with letters to some who had been omitted inadvertently from the previous circularisation.<sup>3</sup>

Altogether 11,594 question forms were sent out. 8,473 returns were received of which 264 related to women who had died or were no longer resident in the United Kingdom. Consequently, the present analysis is based on the information supplied by 8,209 women. An investigation of a sample of one in four of the 3,121 doctors who did not reply, suggested that 2,747 were resident within the United Kingdom. The response rate was thus 75 per cent.<sup>4</sup>

<sup>3</sup> A further check undertaken in 1964, however, showed that 1,038 of those listed never received forms.

<sup>4</sup> 
$$\frac{8,209}{11,594 - (264 + 374)} \times 100 = 75.0$$

Using information supplied by the Editor of the Medical Directory and material available within the Ministry of Health, it was possible to learn something of the nature of the bias due to non-participation. Briefly, the non-respondents were more commonly older women who had qualified earlier and were less likely to be working, especially in general practice, than respondents.<sup>5</sup> It was not possible to indicate how far the non-respondents differed from the respondents in respect of marital or maternal status.

The Ministry of Health kindly made a comparison between the number of women doctors who could have been included in the MPU inquiry and the total number of women doctors in Great Britain on their records. The former amounted to about 12,000<sup>6</sup> and the latter to about 14,000. Most of the difference was accounted for by about 850 doctors who were relatively newly qualified and about 1,100 who had been qualified 20 years or more. The former group is thought to have consisted almost entirely of doctors who registered provisionally in 1962 (only full registrations are included in the Registration lists) and of some from overseas who may not have been included in these lists. The latter group of 1,100 consisted mainly of those excluded from the MPU inquiry because they were marked in the Medical Directory as retired.

The question arises as to how far the findings from the inquiry are applicable to women doctors as a whole. Bearing in mind that doctors who qualified during the years of the study but had only provisional registrations were not included and the fact that the 25 per cent who failed to respond tended to be older than those who responded, it is possible to suggest the directions in which adjustments should be made so that the findings of the inquiry can be applied to women doctors generally, and these are considered in the concluding discussion. That part of the analysis which is concerned with trends and with the relationship between marital and maternal status and work experience is not likely to be materially altered, however, by the omissions and non-response.

The questions asked are reproduced in the appendix. Besides providing information about their marital status, date of marriage, number of children, and whether or not they had

<sup>5</sup> See Appendix. Tables A1, A2, and A3.

<sup>6</sup> 10,956 (footnote 4) + 1,038 (footnote 3) = 11,994.

married a doctor,<sup>7</sup> the informants were asked to give the date of their qualification and to say whether they had obtained any higher degrees or diplomas. They were also asked about their present employment, and if they were not working whether they wished to work. If so, they were asked whether they were prevented from doing so by the absence of suitable work opportunities. They were asked to say how long they had worked since qualification and, if they were not working, whether they would find a postgraduate course helpful before starting again. One or two questions proved ambiguous, and some which would have been useful in the analysis (for example, "Are you expecting a baby?" and "Date of registration") were not asked. Nevertheless, the inquiry yielded a great deal of information about the working and domestic circumstances of over 8,000 women doctors.

<sup>7</sup> 57 per cent of the married respondents had married doctors.

## THE RESULTS

### WOMEN DOCTORS IN FULL AND PART-TIME WORK

Of the 8,209 respondents, 47·1 per cent had whole-time appointments, 34·2 per cent part-time appointments and 18·7 per cent were not working (Table I).<sup>a</sup>

<sup>a</sup> These proportions are almost exactly similar to those found in the survey carried out by the Medical Women's Federation in 1964 to which 7,861 women doctors replied. (cf. Lawrie, J. E., *et al.*, *op. cit.*, 1966).

TABLE I

Respondents in whole and part-time work

<i>Type of work</i>	<i>Number</i>	<i>Per cent</i>
Whole-time	3,863	47·1
Part-time	2,813	34·2
Not working	1,533	18·7
Total	8,209	100·0

Nearly 40 per cent of the whole-time appointments were in general practice and only slightly fewer in the hospital service. Less than 20 per cent were in the public health services and only 6 per cent outside one or other of these three main branches of the National Health Service (Table II).

Some of those in part-time work held appointments in more than one branch of the services. The hospitals provided many fewer part-time than whole-time appointments and in general practice there were approximately only three part-time to every four whole-time appointments. In public health, on the other hand, there were rather more part-timers than whole-timers. Part-time appointments were much more common than whole-time ones in branches of medical practice outside the three main branches of the National Health Service.

**TABLE II**

Respondents by type of appointment

<i>Type of Appointment</i>	<i>Whole-time</i>		<i>Part-time*</i>	
	<i>No.</i>	<i>Per cent</i>	<i>No.</i>	<i>Per cent</i>
Hospital	1,376	35.5	714	25.3
General Practice	1,509	39.2	1,167	41.5
Public Health	746	19.3	772	27.4
Other	232	6.0	1,004	35.7
All	3,863	100.0	3,657*	129.9*

\*As many doctors held appointments in more than one branch of the services, the total exceeds the total of doctors in part-time work which was 2,813.

Whether a doctor was working whole-time or part-time or not at all, the type of work undertaken and the actual compared with the possible years worked were related to age, marital and maternal status, the possession of further qualifications, and area of residence. The relationship between each of these factors and work is now considered.

#### AGE

Over 90 per cent of the respondents aged 50 to 54 were working, and the proportion of workers among those of 45 to 49 was only slightly less (Table III). Among those both older and younger than these age groups, significantly fewer were working. Apart from those aged 65 and over the women doctors least likely to be working were those in their early thirties.

The association of age and working status is not, of course, a direct one. Women doctors of 30 to 40 were more likely than women of other age groups to have a child of less than five, and—as shown later—maternal status and children's age were associated with working status. However, it is probable that factors closely associated with increasing age, such as liability to fatigue and chronic ill-health are the ones which account for the differences in working status of those over and under 54.

**TABLE III**

Age and working status

Age group	Per cent			Total	No. in group
	Working Whole-time	Working Part-time	Not Working		
Up to 29	57.5	20.9	21.6	100.0	1,261
30-34	40.8	35.7	23.5	100.0	1,299
35-39	40.3	38.7	21.0	100.0	1,570
40-44	43.3	39.5	17.2	100.0	1,120
45-49	47.2	40.9	11.9	100.0	881
50-54	55.9	34.2	9.9	100.0	564
55-64	52.8	31.6	15.6	100.0	1,139
65-over	34.1	36.9	29.0	100.0	276
All ages	47.1	34.2	18.7	100.0	8,209*

\*Including 99 age unknown

Not unexpectedly, there was also a relationship between age and type of appointment. The hospitals absorbed 60 per cent of the whole-time workers who were not yet 35 years old, but a substantially smaller proportion of older women (Table IV). On the other hand, the older the women the more likely were they to have part-time hospital appointments. This finding is not peculiar to women but reflects the normal staffing of hospitals, in which most posts below that of senior registrar are on a full-time basis, whereas many consultant posts are part-time appointments.

**TABLE IV**  
Age and type of appointment

Age	Whole-time appointments (per cent)				Part-time appointments (per cent)			
	Hospital	General Practice	Other	All	Hospital	General Practice	Other	All
Up to 34	60.1	23.8	16.1	100.0	15.7	53.4	55.9	124.0
35-44	27.4	45.0	27.6	100.0	21.7	41.1	68.0	130.8
45-over	21.3	47.8	30.9	100.0	36.3	33.4	61.9	131.6

### MARITAL AND MATERNAL STATUS

The relationship between marital and maternal status and work is shown in Table V. Well over 90 per cent of single women doctors were working, the great majority of them on a whole-time basis. The proportion of widowed and divorced who worked was almost as great but fewer of them had whole-time appointments, probably because rather more than two-thirds of them had children.

**TABLE V**

### Marital and Maternal Status and Work

<i>Marital and Maternal Status</i>	<i>No. in group</i>	<i>Per cent</i>			<i>Total</i>	<i>Per cent of workers working whole-time</i>
		<i>Working whole-time</i>	<i>Working part-time</i>	<i>Not working</i>		
Single	2,437	81.7	12.6	5.7	100.0	87
All Widowed and Divorced	457	62.4	29.7	7.9	100.0	68
Married/Childless	1,032	54.4	28.8	16.8	100.0	65
Married/Child(ren) under 5	2,058	17.3	46.1	36.6	100.0	27
Married/Child(ren) not under 5	2,217	30.1	50.5	19.4	100.0	37

Childless married women were less commonly working than were single women and, if they were working, were less likely to have whole-time work. Some of the childless married women may have been expecting a baby at the time of the inquiry and have stopped work in anticipation of the event. However those who were pregnant with their first child are unlikely to have been sufficiently numerous to alter the general conclusion that marriage irrespective of child-bearing acts as something of a barrier to work.

Married women with at least one child under 5 were unlikely to be working whole-time. Only 17 per cent or approximately one in six of them had such appointments. However, those whose child or children had reached compulsory school age were almost as likely to be working as childless married women, although more of them worked part-time only.

Whether or not a woman worked seemed to be determined more by the age of the child or children than by the number of children she had (Table VI). There was little difference between the proportions of mothers of one, of two, of three and of four or more children who worked when at least one of the children was under school age.

**TABLE VI**

Number of children and working status

*(Married doctors with at least one child of less than 5 years old)*

<i>No. of children</i>	<i>No. of women</i>	<i>Per cent</i>		<i>Total</i>	<i>Per cent of workers working whole-time</i>
		<i>Working</i>	<i>Not working</i>		
1	525	60.8	39.2	100.0	35
2	694	62.8	37.2	100.0	26
3	539	66.2	33.8	100.0	22
4	300	65.0	35.0	100.0	28

Those women who indicated that they had part-time appointments were asked whether such appointments were on a regular basis and whether they occupied more than 50 per cent or more than 25 per cent of their time.

The amount and regularity of part-time work was related to both marital and maternal status (Table VII). The majority of single women, who indicated how long they worked, worked for more than half their time. The proportion of married women working as much as this was considerably less, especially among those with a child under 5 years old.

**TABLE VII**

Marital and maternal status and the amount of part-time work  
(*part-time workers only*)

<i>Marital and maternal status</i>	<i>No. of part-time workers</i>	<i>Per cent working:</i>					<i>Total</i>
		<i>More than half-time</i>	<i>Quarter to half-time</i>	<i>Less than quarter</i>	<i>Irregularly</i>	<i>Not stated</i>	
Single	308	40.2	12.7	10.4	8.1	28.5	100.0
Married (all)	2,368	22.2	34.8	17.9	19.0	6.1	100.0
Married (childless)	298	31.2	29.2	10.4	20.1	9.1	100.0
Married (child-(ren) under age 5)	950	14.0	36.6	21.7	24.3	3.4	100.0
Married (child-(ren) age 5 or over only)	1,120	26.7	34.7	16.6	14.2	7.8	100.0

There were substantial differences in the type of whole-time appointment held by doctors of different marital and maternal status. Single and childless married women were most commonly found in the hospital service; but hospitals employed relatively few of the whole-timers with children (Table VIII). General practice, on the other hand, absorbed more of the married women with children and widowed and divorced women than either the hospital service or public health. Public health was a more important source of employment for the whole-timers with children than for those without.

Respondents were asked to indicate how many years they had worked since qualifying, and their answers were used to calculate the years actually worked as a percentage of the total years since qualification of women of different ages and marital status.

**TABLE VIII**

Marital and maternal status and type of whole-time appointment

<i>Whole-time appointment</i>	<i>Single women</i>	<i>Married</i>		<i>Widowed and divorced</i>	
		<i>Childless</i>	<i>With children</i>	<i>Childless</i>	<i>With children</i>
	%	%	%	%	%
Hospital	44.0	44.7	18.3	30.2	16.4
General Practice	34.2	31.0	50.7	44.8	48.7
Public Health	16.1	17.3	24.8	19.8	29.1
Other	5.7	7.0	6.2	5.2	5.8
All appointments	100.0	100.0	100.0	100.0	100.0
No. in group	1,991	561	1,025	96	189

Marriage and motherhood are not, of course, the only reasons for being temporarily or permanently without employment. Ill-health, the non-availability of suitable work, preferences for other kinds of work and many other factors may curtail the actual years spent in work in the field in which qualifications were acquired. Nevertheless, single women on average were at work for over nine out of every ten years since qualification. Not unexpectedly, married women, on average, had not been able to sustain such a high proportion of work years in their total years since qualification. Their average performance is shown in Table IX expressed as a proportion of the performance of single women of the same age.

Differences between single and married in the average proportion of post-qualification years actually worked were most pronounced among women doctors of 30 to 44. Married women respondents aged 45 and more had, on average, worked for between three-quarters and four-fifths as many years as single women of the same age. A large part of the years worked by married women is likely to have been in part rather than whole-time employment; consequently the overall comparison between the single and the married is not likely to be quite as favourable as that shown by the figures in Table IX. This is an aspect of the problem which could not be properly elucidated from the brief and general information obtained in response to one question. It needs more detailed investigation.

**TABLE IX**

Average number of potential work years actually worked by married women doctors expressed as a ratio of the average years worked by single women of the same age

<i>Age group</i>	<i>Ratio</i>
Up to 29	0.77
30-34	0.71
35-39	0.69
40-44	0.72
45-49	0.77
50-54	0.77
55-64	0.80

#### FURTHER QUALIFICATION AND WORK

Just under a half (46.5 per cent) of the respondents had obtained a qualification in addition to their basic medical qualification. A few had first degrees in arts, science or law acquired for the most part before qualifying in medicine, and a small number had qualifications in non-medical work (for example, teaching) or in professions allied to medicine like dentistry, nursing, veterinary medicine or physiotherapy. There were also a few whose only further medical qualification was a certificate taken after a few weeks' instruction which enabled them to practise certain skills and techniques, for example, family planning and contraceptive fitting and the ascertainment of individuals with subnormal intelligence. In all there were only some 300 women with any one of these categories of qualification in addition to their basic medical qualification. The remainder (some 3,500) had either higher degrees or diplomas in one of the specialities of medicine awarded after some years or months of continuous whole-time or part-time studies.

A comparison between those with and without additional qualifications showed that those with them were rather more likely to be working and to work whole-time if they did so than those without qualifications (Table X).<sup>9</sup> It is not possible, on the data available, to say whether those with further qualifications were more commonly working princi-

<sup>9</sup> This finding is comparable with that of the Medical Women's Federation inquiry. They also found that 46 per cent of their respondents had additional qualifications, and that only 15 per cent of those with additional qualifications were not working compared with 25.5 per cent of those with no additional qualifications. (Lawrie, *et al.*, *op. cit.*, 1966.)

pally because they had greater interest in their work which manifested itself, among other things, in the decision to study for a further qualification, or because they found it easier to find suitable employment than doctors who had only a basic medical qualification. It is possible that both factors operate. However, the difference in respect of women with and without further qualifications was certainly not as great or as important as the differences in the work patterns of women of different marital and maternal status.

TABLE X

Additional qualifications and work

Work	Qualifications	
	Additional Per cent	No additional Per cent
Working	85.9	77.3
Not working	14.1	22.7
Total	100.0	100.0
Per cent of workers in whole-time work	61	55
No. in group	3,818	4,391

TABLE XI

Regional Hospital Board area and work

<i>Regional Hospital Board area</i>	<i>Total number of women doctors</i>	<i>Per cent working</i>	<i>Per cent of workers in whole-time work</i>
Birmingham	538	86	52
S.E. Metropolitan	690	85	57
N.E. Metropolitan	445	85	61
N.W. Metropolitan	718	85	60
Liverpool	325	85	59
Leeds	383	85	62
Manchester	471	83	54
S.W. Metropolitan	851	83	55
Newcastle	358	82	55
Wales	312	82	61
Sheffield	470	80	58
Wessex	210	80	52
East Anglia	202	79	52
South-Western	397	79	44
N. Ireland	157	77	50
Oxford	258	73	51
Scotland (all R.H.B.'s)	1,086	71	67

## AREA OF RESIDENCE AND WORK

There were considerable differences in the proportion of women doctors working in different parts of the country (Table XI). Generally speaking, a larger proportion of those living in the Birmingham and Metropolitan Regional Hospital Boards and in predominantly urban hospital board areas in the north of England were working compared with those in hospital board areas with proportionately larger rural populations.<sup>10</sup>

<sup>10</sup> These findings are comparable to those of the Medical Women's Federation. (cf. Lawrie, *et al.*, *op. cit.*, 1966.)

There were some differences in the proportion of workers in whole-time work in different regional hospital board areas; but there is no easy explanation for these differences. Scotland stands out from most other areas in this respect, and it is possible that the combination of the lowest percentage of working doctors with the highest proportion of whole-timers among workers denotes a comparative paucity of opportunities for part-time work north of the border. This, in its turn, may reflect a more favourable supply of male doctors compared with England and Wales generally, or a greater reluctance on the part of potential employers of medical personnel in Scotland to make part-time appointments.<sup>11</sup>

The comparatively greater employment opportunities of London and its immediate surroundings and of the north and midlands compared with the non-metropolitan south is shown more clearly when the respondents were divided into five groups according to the part of the country in which they lived (Table XII).

<sup>11</sup> The data for women resident in Scotland were not analysed by Regional Hospital Board area.

**TABLE XII**

Area of residence and work

<i>Area of residence</i>	<i>Per cent of women doctors working</i>
London and Middlesex	88
County Boroughs <i>north</i> of Wash—Bristol Channel line	85
Counties <i>north</i> of line	82
Counties <i>south</i> of line	80
County Boroughs <i>south</i> of line	76

#### THE UNSATISFIED DESIRE FOR WORK

There were 1,067 women among the 1,533 who were not employed who said they wished to work, the great majority wanting part-time rather than whole-time work. The desire for work was most commonly expressed among the youngest non-employed doctors (Table XIII).

**TABLE XIII**

The wish for work among non-employed women doctors

Age group	Total number	Per cent			Total
		Wanting to work Part-time	Whole-time	Not wanting to work	
Up to 34	577	81.6	7.3	11.1	100.0
35-49	628	69.7	5.1	25.2	100.0
50-64	234	26.5	4.7	68.8	100.0
65 and over	80	10.0	3.7	86.3	100.0
All ages	1,533*	63.9	5.7	30.5	100.0

\*Includes 14 whose age was not stated.

The question upon which this analysis is based was not entirely free from ambiguity and it is possible that some of those who said they wished to work were thinking in terms of some time in the future rather than the present. Nevertheless, it is legitimate to conclude that well over three-quarters of the women doctors who were not yet 50 and who were not employed at the time of the survey wanted work mainly of a part-time nature at the time or later.

Of the 2,813 respondents who were working on a part-time basis, over a third (36 per cent) said they could do more work if it were available. There were proportionately more involuntarily under-employed among younger women than among older ones (Table XIV).

**TABLE XIV**

**Part-time workers wanting more work**

<i>Age group</i>	<i>Total number</i>	<i>Per cent</i>		<i>Total</i>
		<i>Wanting more work</i>	<i>Not wanting more work or not stated</i>	
Up to 34	728	44.1	55.9	100.0
35-49	1,410	38.4	61.6	100.0
50-64	555	23.9	76.1	100.0
65 and over	102	19.6	80.4	100.0
All ages	2,813*	36.3	63.7	100.0

\*Including 20, no age stated.

The associations between work and the marital and maternal status of women doctors which have already been demonstrated suggested that the domestic circumstances of mothers with young children were the main reasons for both non-employment and under-employment. This conclusion received further confirmation from the response to the question 'if you wish to work, why are you unable to now?' which was asked of those who were not working but expressed a wish to do so (Table XV).

The responses could be divided into four kinds. First, there were those who specified only domestic difficulties or family responsibilities as reasons for not working; secondly, those who indicated that there was not suitable work available, whether this was work in a suitable specialty or work with suitable hours; thirdly, those who gave a combination of domestic and work difficulties as reasons for not working, and finally a number who gave no reason for not being able to work.

It is not legitimate to read too much into the figures given in Table XV, but it is reasonable to assume that, in answering the question, the respondents gave what they perceived to be the *main* difficulty in returning to work. Among those under 50, more emphasised domestic and family difficulties than the absence of suitable employment.<sup>12</sup> It is possible, moreover, that those who gave only domestic responsibilities as their reason for not working had not investigated work opportunities, whereas those who gave work reasons as well had sought

<sup>12</sup> (See Table XV.) Proportion in categories B plus C is greater than proportion in categories A plus C for age groups under 50; but less for those aged 50 and over

work but failed to find any which they could combine with their continued domestic responsibilities. It seems probable that those who mentioned the absence of suitable work opportunities as a reason for not working who formed well over half those who said they wished to work (categories A and C in Table XV) had taken some active steps to explore the possibilities and had been unable to find something to suit them.

**TABLE XV**

Reasons given for not working by those who wished to do so

Reason for not working	Age Group			
	Up to 34	35-49	50 or over	All ages
	%	%	%	%
A No suitable work	24.7	21.1	33.4	23.8
B Domestic reasons only	37.8	37.0	20.2	36.1
C Domestic reasons plus lack of suitable work	32.4	35.7	23.8	33.2
D Not stated	5.1	6.2	22.6	6.9
All reasons	100.0	100.0	100.0	100.0
No. in group	513	470	84	1,067

Married women were asked whether their husbands approved of their working. The question was intended to apply to those who were not working as well as those who worked, but was not answered by nearly 10 per cent of the former. A study carried out in 1957 by Klein<sup>13</sup> suggested that a third of all husbands disapproved entirely of their wives working; but that among husbands in the professional and business classes the level of such disapproval (27 per cent) was rather less. Married women when asked in the same inquiry whether their husbands disapproved, were less inclined to say they did, only 19 per cent of them saying that their husbands disapproved unconditionally.

Married women doctors in 1962-63 were less likely to say that their husbands disapproved of their working than women in this earlier inquiry (Table XVI). Indeed, 92 per cent of all married women indicated that their husbands approved of their working. Not surprisingly, the level of approval was somewhat less among those whose wives were not working, but husbands' disapproval does not seem to have been an important factor in preventing women from working.<sup>14</sup>

<sup>13</sup> Viola Klein (1965), 'Britain's Married Women Workers'.

<sup>14</sup> There were no differences in husbands' approval according to whether or not they were doctors themselves. Wives whose husbands were not doctors were slightly more likely to be working than those whose husbands were doctors (77 per cent against 73 per cent) but these differences were not statistically significant.

**TABLE XVI**

Husbands' attitudes to their wives working

<i>Husbands' Attitudes</i>	<i>Wives</i>		
	<i>Working</i>	<i>Not working</i>	<i>All wives</i>
	%	%	%
Approval	95.2	83.0	92.1
Disapproval	2.2	7.9	3.7
Not stated	2.6	9.1	4.2
All husbands	100.0	100.0	100.0
No. in group	3,954	1,353	5,307

A considerable proportion of the respondents and especially of those who were not working did not answer the question 'Is it financially worthwhile for you to work?' But definite answers were strongly associated with a woman's working state (Table XVII). Only 11 per cent of the married women who were working, considered it not financially worthwhile; but the proportion holding such a view was considerably greater among those who were not working.

**TABLE XVII**

Married women's attitudes to the financial incentive of work

<i>Attitude expressed to work</i>	<i>Married women</i>			
	<i>Working</i>	<i>Not working but wishing to</i>	<i>Not working and not wishing to</i>	<i>All married</i>
	<i>%</i>	<i>%</i>	<i>%</i>	<i>%</i>
Financially worthwhile	82.6	54.6	23.1	73.5
Not financially worthwhile	11.3	27.6	33.2	15.8
No opinion expressed	6.1	17.8	43.7	10.7
All attitudes	100.0	100.0	100.0	100.0
No. in group	3,954	1,028	325	5,307

The proportion who considered that little was to be gained financially from working increased with age (Table XVIII). It is probable that more of the older married women than of the younger ones would have husbands with incomes already subject to surtax or likely to be surtaxed if their wives also earned. In such circumstances wives' earnings, especially if they were working on a part-time basis only, would make little net contribution to the joint income, especially if the expenses incurred in working were heavy. For such women the financial rewards of part-time medical work may be so small as to be no incentive.

**TABLE XVIII**

Married women doctors' attitudes to the financial incentive of work by age  
(Only respondents not working but wanting to)

<i>Attitude expressed to work</i>	<i>Age groups</i>			
	<i>up to 34</i>	<i>35-39</i>	<i>40-44</i>	<i>45 and over</i>
	<i>%</i>	<i>%</i>	<i>%</i>	<i>%</i>
Financially worthwhile	64.2	53.7	43.5	36.7
Not financially worthwhile	20.1	26.9	37.2	41.4
No opinion expressed	15.7	19.4	19.3	21.9
All attitudes	100.0	100.0	100.0	100.0
No. in age group	502	242	145	139

## MARRIAGE AND MOTHERHOOD

Caution has to be exercised in interpreting the relationships of variables which are statistically associated with one another. It is, for example, possible that marriage and maternity are results rather than causes of the positive association found between these states and non-employment among women doctors. In other words, because they are not working some women may choose to marry and have children. However, on the evidence provided in this survey,<sup>15</sup> it is plausible to conclude that marriage and maternity are more frequently causes than consequences of qualified women not working. For this reason, information about the extent of marriage and particularly about trends in the age of marriage and in family size among women doctors is of great significance, since it provides the basis for calculating the potential number of trained medical women available for work given the continuation of present trends.

Compared with the adult female population of England and Wales in 1961, proportionately more of the women doctors responding to the MPU enquiry in 1962 had never married (Table XIX). In each five year age group from 30 to 54 and in the ten year age group 55 to 64, there were at least proportionately twice as many spinsters among women doctor respondents as amongst the female population generally.

However, a comparison of the marital condition of different age groups suggests that marriage is a more common condition

<sup>15</sup> For example, evidence that a majority of married women without work wanted to work and that a majority of the part-timers wanted more work suggested that marriage and maternity was more often associated with involuntary than with voluntary non-employment.

for both women doctors and women in the general population of less than 50 years old than it was for generations which are now over 50. Indeed, the proportion of 30 to 34 year olds already married of both the female population and the women doctors already exceeded the comparative proportion of 50 to

### TABLE XIX

The marital status of women doctor respondents and the female population of England and Wales in 1961

(per 1,000 in each age group)

Age Group in years	Doctors			Population*		
	Single	Married	Widowed and Divorced	Single	Married	Widowed and Divorced
20-24				420	577	2
25-29	381	619	—	157	835	9
30-34	273	719	8	109	875	15
35-39	236	744	20	98	875	27
40-44	229	734	37	97	859	44
45-49	222	695	83	105	828	67
50-54	328	583	89	122	778	99
55-64	359	470	171	141	661	198
65 and over	465	349	186	156	343	502

\*Registrar General. Census 1961.

54 year olds. In the 20 years that it will take the present generation of 30 to 34 year olds to reach 50 to 54, it is probable that many more will have married and the ultimate disparity between the two generations will, therefore, be even greater.

While there has thus been a trend to marriage among both women doctor respondents and women generally, the trend has been more marked among doctors. The result is that although disparities still exist in the marital condition of women doctors and the female population they are less marked among those aged 30 to 49 and especially among the 45 to 49 year olds, than they are among those of 50 or more.

There remains, however, a considerable difference in the marital status of women doctor respondents and of women in the general population under the age of 30, and this is due to the fact that the former commonly married at an older age than the latter. For the population as a whole there has been a steady decline in the average age of brides at marriage<sup>16</sup> and a spectacular increase in the proportion of brides who were less than 25 years old (Table XX). Among women doctor respondents, on the other hand, there was a decline in the proportion of brides who were less than 25 years old from a peak of 33 per cent of those married during the war years to 17 per cent of those who married in the years 1960-63. These figures contrast with those for the female population as a whole which rose from 57 per cent of spinster brides married during the year 1938 to 80 per cent of those marrying during 1961-62.

<sup>16</sup> It was not possible to calculate the average age at marriage of women doctors to compare with that of the population.

**TABLE XX**

Comparisons between the proportion of married women doctor respondents and the married female population who married under the age of 25

<i>Year of marriage</i>	<i>Per cent of married women marrying before the age of 25</i>	
	<i>Doctors</i>	<i>Population (England and Wales*)</i>
1931	—	57·8
1938	—	57·2
1940-44	33·4	—
1945-49	31·1	—
1939-50	—	66·0
1950-54	28·5	—
1951-55	—	72·3
1955-59	27·9	—
1956-60	—	77·5
1960-63	16·7	—
1961-62	—	80·1

\*Registrar General's Statistical Review, 1962, Part II.

**TABLE XXI**

The relationship of marriage to qualification

Marriage	Year of qualification						
	1920-29	1930-39	1940-44	1945-49	1950-54	1955-59	1960-63
Before qualification	3.5	3.4	7.5	8.5	12.7	10.4	12.0
Same year as qualification	4.3	4.8	8.1	7.8	7.6	10.5	12.2
1-2 years after qualification	9.9	16.8	19.3	21.2	23.3	26.7	30.8
3-4 years after qualification	10.8	14.5	16.0	16.7	13.8	11.8	0.8
5-9 years after qualification	18.0	19.9	17.5	17.6	15.2	4.5	—
10 or more years after qualification	15.9	12.0	7.2	6.0	1.7	—	—
Year of marriage unknown	0.5	0.8	0.5	0.3	0.2	0.3	—
Unmarried at date of inquiry	37.1	27.8	23.9	21.9	25.5	35.8	44.2
All women	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. in group	1,137	1,128	1,055	1,440	1,468	1,444	493

**MARRIAGE AND QUALIFICATION**

A clue to the reasons for the difference in the age at which women doctors and the female population in general marry is to be found in the relationship in time between marriage and qualification (Table XXI).

The proportion of women who have married at least one calendar year before qualifying has been showing a marked tendency to rise. Less than 4 per cent of those respondents qualifying before 1939 married a year or more before qualifying. In the nineteen-forties the proportion about doubled and since 1950 has been about three times as high as it was before the war.<sup>17</sup> So too has been the proportion of women doctors marrying in the same calendar year as they qualified. Nevertheless, it is still a small minority who marry more than a year before qualification. Postponement of marriage until the year of qualification or the years immediately following it is thus the ostensible reason why a comparatively small proportion of women doctors married under 25. Moreover, as Table XXII indicates, there has been a tendency for the proportion of women qualifying before the age of 24 to fall. This may reflect a tendency for medical students to enter medical school at a rather older age than they did before, during and immediately after the second World War.

<sup>17</sup> Women respondents who qualified earlier are likely to be less representative of the cohort qualifying than respondents who qualified later are of theirs, since a larger proportion of the early group will have retired and been left off the register or have died.

**TABLE XXII**

Proportion of women doctors qualifying under age 24

<i>Per cent qualifying</i>	<i>Year of qualification</i>				
	<i>1940-44</i>	<i>1945-49</i>	<i>1950-54</i>	<i>1955-59</i>	<i>1960-63</i>
Under 24 years old	49.0	55.2	39.9	35.7	30.2
No. in group	1,046	1,426	1,454	1,433	491

At the time of writing, data from the census of 1961 which would allow a comparison of the age and fertility of married women doctors with that of wives of professional men are not available. Data from the 1951 census do not provide a very satisfactory comparison; but, if they are used (Table XXIII), it would seem that women doctors aged 45 to 49 in 1962-63 were much less likely to marry under 25 than women of comparable age a decade earlier who had married professional men. These latter in their turn married later than women of the same age in the general population.

**TABLE XXIII**

Comparison between the age of marriage of women doctors aged 45-49 in 1962-63 and of all women in England and Wales and wives of men classified in Social Class I, aged 45-49 in 1951

(per 1,000 marriages)

<i>Age at marriage</i>	<i>Women doctors</i>	<i>Social Class I wives*</i>	<i>All women*</i>
Under 25	188	365	525
25-29	470	408	299
30-34	236	145	104
35-39	70	48	42
40 and over	36	34	30
All ages	1,000	1,000	1,000

\*Data from Census 1951. 'Fertility Report', Registrar General, H.M.S.O. 1959.

Satisfactory comparisons between the fertility of married women doctors and various sections of the population must also wait upon the full publication of the 1961 Census data. If an admittedly unsatisfactory comparison is made between the numbers of children of doctors in 1962-63 who were likely to have completed their families (that is those aged 45 to 49) and the similar age group of wives of Social Class I men and of all occupied men, it suggests that married women doctors may well be having larger families than the wives of either most professional men or of the general population (Table XXIV). Nearly three-quarters of the married women doctors aged 45 to 49 in 1963, for example, had at least two children, whereas the comparable proportion among wives of professional men a decade earlier was only 48 per cent.

**TABLE XXIV**

Comparison between the completed family size of married women doctors in 1962-63 and all wives and Social Class I wives in 1951

(*Married women aged 45-59*)

<i>No. of children</i>	<i>Women doctors</i>	<i>Social Class I wives</i>	<i>All wives</i>
	<i>%</i>	<i>%</i>	<i>%</i>
0	12.4	24.4	20.2
1	15.3	27.6	26.3
2	28.9	29.5	24.0
3	27.1	12.6	13.1
4 or more	16.3	5.9	16.4
All	100.0	100.0	100.0
No. in group	685	30,585	238,301

It is possible that there has been an increase in the size of completed families in the population generally which would narrow the gap between women doctors and other married women. Nevertheless, there are indications that the size of completed families of younger married women doctors may be even greater (Table XXV). The proportion of those aged 35 to 39 in 1962-63 who had at least two children was already greater than the comparable proportion of women of 45 to 49.

**TABLE XXV**

Number of children of married, widowed and divorced doctors

<i>Number of children</i>	<i>Age of doctor</i>			
	30-34	35-39	40-44	45-49
0	15.2	11.4	14.8	12.4
1	19.7	11.4	14.8	15.3
2	35.8	32.5	28.6	28.9
3	21.9	30.2	21.2	27.1
4 or more	7.4	14.5	20.6	16.3
All	100.0	100.0	100.0	100.0
No. in group	942	1,196	764	685

## DISCUSSION AND CONCLUSIONS

### **THE DILEMMA—A CAREER AND/OR MARRIAGE AND MOTHERHOOD?**

The amount of work which professionally qualified women are able to do is a matter of national importance. The training of medical students now represents an investment of public rather than private resources. The community needs doctors and has a right to expect a reasonable return from those it trains in the form of practice over a number of years.

Equally, the quality of family life is a matter of public as well as private concern, and it is widely felt by both men and women that mothers must spend a considerable proportion of their time with their children, especially in the pre-school years, if the emotional development of their offspring is not to be jeopardised.

The result is that qualified women in attempting to pursue simultaneously their professional work and their parental and marital duties face many material difficulties and conflicts of loyalties. Moreover, the woman doctor's personal dilemma is not always one of short duration, resolved when the child begins to spend most of his time outside the home. A doctor who does not practise for several years may lose or feel she has lost her professional skills or aptitudes and may be unable or unwilling to re-enter her profession when the burden of her domestic commitments is lightened.

Nor is the dilemma one for women doctors to resolve individually. The community too faces conflicts of interests. On grounds of equity it does not wish to exclude women or restrict their entry to medicine, but it may feel obliged to do so on economic grounds if the return it obtains from qualified women is out of all proportion to what it obtains from men who could be admitted to the profession in greater numbers.

The responses from the 8,209 women doctors who completed the question form sent out by

the Medical Practitioners' Union in 1962-63, serve to indicate the nature and size of the problems associated with using the skills and training of medical women. These women represented about two-thirds of the total number of women doctors who qualified after 1920 and were resident in the UK in 1962-63, and it is not possible, therefore, to provide from their responses quantitative statements concerning all medical women. Nevertheless, it was possible to examine some of the characteristics of those who were not covered. This examination showed that the inquiry under-represented on the one hand those doctors who were under 30 and had only just gained their qualification, and, on the other, doctors in their late fifties and early sixties who were nearing retiring age. The information obtained for these two age groups is less reliable, therefore, than the information obtained concerning doctors between the ages of 30 and 54.

#### **INESCAPABLE FACTS**

Some major conclusions are prompted by the analysis of the responses. First, for example, it is clear that women doctors in the recent past have been less likely to marry before the end of their child-bearing years than women generally. However, the disparity in this respect between women doctors and the generality of women is growing smaller. Given the continuity of present trends, over 85 per cent of those qualifying in medicine may expect to marry. Secondly, if current trends continue, a small but growing proportion of medical women will marry at least one year before qualifying. The majority, however, will marry either in the year in which they qualify or in the four years following qualification. Consequently, although women doctors will marry on average several years later than women generally, most will have married by their thirtieth birthday.

Thirdly, women doctors who marry are not likely to remain infertile. Only 12 per cent of those aged 45 to 49 in 1962-63 were childless, and among those of 30 to 34, 85 per cent had already had at least one child. Indeed, although data for the same period concerning the family size of all women are not available at the time of writing, it is possible that the completed families of women doctors in 1962-63 were larger than those of wives of professional men.

It must be assumed, therefore, that only a few women who enter the medical profession are likely to remain single and childless. On the evidence provided by the MPU study, nearly all of those who do not marry will work on a whole-time basis from the time they qualify until they retire on account of age, although, in later middle age, a small proportion will work either part-time or not at all. Poor health may be the main reason for this small reduction in the amount of whole-time work. There appear to be no substantial difficulties to be overcome in making full use of the professional skills of such women.

On the other hand, marriage, even when it is not followed by motherhood,<sup>18</sup> leads to some withdrawal from employment, and some switch from whole to part-time work. Only 54 per cent of the married childless women respondents worked whole-time compared with 82 per cent of the single women, and the proportion without employment increased from 6 per cent among the single to 17 per cent among the married and childless. If the tendency to marry before or at about the same time as qualification continues, and other things remain constant, the proportion of young recently qualified women in whole-time work is likely to fall.

An even more important factor in the withdrawal of women doctors from whole-time employment is the presence of a child of pre-school age in the family. Only one in six of the women doctor respondents in this position were in whole-time work, and over a third were not working at all. Those with a child or children of school age or above are almost as likely to work as childless married women, but they are less likely to be in whole-time work.

The general effect of motherhood, therefore, is to lead to a substantial initial but temporary withdrawal from employment of any kind and an equally substantial and more lasting switch from whole- to part-time employment. While 80 per cent of women doctor respondents with children of school age or over were at work, less than a third were in whole-time work. Consequently, if the tendency for doctors who marry to have at least one child continues, and other things remain unchanged, it is likely that more, not less, women doctors will be lost to both whole-time and part-time work especially in the years immediately following qualification.

<sup>18</sup> Some of the younger childless married women may have been pregnant at the time of the survey and withdrawn from work or undertaken part-time duties for this reason.

In brief, the data provided by the respondents to the MPU inquiry make it clear beyond all reasonable doubt that marriage and motherhood in combination are mainly responsible for the premature withdrawal of women doctors from professional work and for the substantial numbers who undertake part-time rather than whole-time work.

#### THE DESIRE FOR WORK

What light does the survey throw on possible ways of increasing the contribution which trained medical women can make to the health services? Clearly, if women who are not working do not wish to work and those who have part-time or irregular appointments do not feel that they can do more professional work, little can be done to increase the work performed, unless coercive measures are used.

The evidence supplied by the respondents to the MPU study, however, suggested that about two-thirds of the unemployment among them was involuntary rather than voluntary and that over a third of the part-timers felt they were under-employed and could do more. In other words, there were at least 1,000 women, and possibly more if those excluded or failing to respond to the inquiry were included, who in 1962-63 were not working at all and would have liked to do some work. These were generally women in their thirties and forties. There were also another 1,000 in part-time appointments who wanted more work. These women too were concentrated in the lower age groups.

It is difficult to estimate exactly in terms of whole-time equivalent workers the additional contribution which these doctors could make to medical manpower resources. Very few of those who were not working at all wanted whole-time work, and those part-timers who felt they were under-employed were not asked how many extra hours or sessions a week they could put in. Assuming, however, that the 2,000 women who said they wanted work or could do more than they were then doing could each have given a day, or an additional day a week (roughly 20 per cent of a working week) to medical work, the supply of doctors would be increased by approximately 400 full-time equivalents. This figure is likely to be a minimum since it does not make any allowance for women who were not included in or failed to respond to the inquiry.

#### THE DIFFICULTIES OF WORKING

It is also possible to indicate very generally from replies to the survey, the difficulties women themselves feel they meet in finding and keeping work. Husbands' disapproval of their wives working is not one of them. Few women who were not working considered that their husbands were hostile to their working. Most of those who want to work but are not doing so, especially those of less than age 50, have difficulties in making adequate domestic arrangements for the care of their family and household. These difficulties are mainly those of finding and retaining the services of domestic staff of the right calibre for the required time each day or week. Less commonly, respondents indicated that the cost of adequate replacement labour in the home, especially for those with irregular part-time work, more than outweighed the financial rewards to be obtained from work. The existence of a positive financial disincentive to work was more commonly mentioned by older women, while younger women stressed the practical difficulties of domestic life when there were young children to be considered.

For many women doctors, however, the difficulties of making adequate domestic arrangements to enable them to work are exacerbated by the uncertainties of the work situation. As many letters which accompanied the returned forms showed, it is usually difficult if not impossible to make adequate domestic arrangements for the care of small children and a household if the only work available to the professional woman is irregular work on an emergency basis or temporary locum posts for general practitioners and public health staff. The survey indicated very clearly that there is a major unmet demand on the part of young women doctors with families for regular part-time work. If this were available within reasonable travelling distance of their homes, the majority of those who are not working as well as a considerable number who have only minor working commitments could be absorbed into medical work with profit to themselves and to the health services as a whole.

#### EASING DOMESTIC DIFFICULTIES

The major issues therefore are two. First, whether any measures can be taken to make better provision for the care of children so that their medically qualified mothers can work, and secondly whether the work for which trained medical personnel is essential can be so re-

organised in the future as to absorb increasing numbers of workers in regular but limited duties each week. The two issues are clearly linked.

Where provision for the care of very young children is concerned, those respondents who commented tended to agree that the most satisfactory form of care was that which could be provided in the home itself. If this is the case, the solution lies in the personal arrangements which the individual mother makes, and the continuing shortage of people willing to undertake child-minding and domestic work in other people's houses is not likely to ease the situation.

Some doctors, however, suggested that more could be done by the community or the employing unit to enable mothers to work. Some advocated the establishment of crèches in hospitals for the use of women doctors and other professional groups whose labour was also much needed such as nurses, physiotherapists, radiographers and medical social workers. Others deplored the absence in most localities of nursery schools and classes. They emphasised that such provision for the two to five year olds would be beneficial to the children and at the same time allow mothers to undertake part-time professional work.

#### **PROVIDING PART-TIME WORK IN HOSPITALS, GENERAL PRACTICE AND LOCAL HEALTH SERVICES**

Measures to ease the domestic and child-minding difficulties of married women doctors will make it easier for many of them to offer their services to potential employers or partners. At the same time, it is also clear that however satisfactory the domestic situation many married women do not feel able or willing to accept whole-time appointments especially when their children are very young. If more of them are to be brought back into active practice, therefore, they must be offered appointments which only commit them for a portion of their working week.

In 1962-63, hospitals employed over 35 per cent of the women doctors who had whole-time appointments but only 19 per cent of those who worked part-time. Many women respondents suggested that the demanding and inflexible conditions attached to junior posts in the hospital service had precluded them from it and, consequently, from obtaining a higher qualification in a speciality of their own choice. The absence of such a qualification in its turn made a

return to work in the hospital service after a period of enforced withdrawal difficult if not impossible.

There seems to be no good reason why much of the work undertaken by junior and middle grade hospital staff should not be done on a part-time basis as is much consultant work at present. Given adequate information about work load it should be comparatively straightforward to schedule the staffing requirements for out-patient, in-patient, laboratory and casualty services in such a way as to offer regular, part-time work to married women which recognises their child-rearing and domestic responsibilities. If this were done, women would be able to keep abreast of current developments in medicine and would not need the intensive re-training which total withdrawal for any prolonged period inevitably involves.

In some specialties, like obstetrics and surgery where some night and week-end work is unavoidable, an unfair burden could be placed on whole-time staff if considerable numbers of married women were to be offered part-time employment during the day. Women who want to enter these specialties must be prepared to do a share of the week-end and night work. However, if this were organised in such a way that women were able to plan their domestic arrangements ahead, the problems should not be insuperable.

General practice in 1962-63, like the hospitals, employed a smaller proportion of those with part- than whole-time appointments.<sup>19</sup> There are many ways in which women doctors could be drawn into the work of a practice on a regular but part-time basis and in the capacity of either partner or assistant. They could, for example, be asked to make regular, unsolicited house calls to the very elderly. Recent studies such as that conducted by Williamson and his colleagues in Edinburgh<sup>20</sup> indicated that many old people do not consult spontaneously for conditions which can cause pain, discomfort and chronic invalidism and which, given regular attention, can be prevented. Part-timers could participate in the domiciliary care and treatment of younger groups of mentally disordered and subnormal patients and physically handicapped individuals whose needs can also be overlooked by busy general practitioners.

<sup>19</sup> 32 per cent of part-timers as compared with 39 per cent of whole-timers.

<sup>20</sup> Williamson, J., Stokoe, I. H., Gray, S., Fisher, M., Smith, E. A., McGhee, A., Stephenson, E. (1964), *The Lancet*, i, 1117-1120, 'Old People at Home'.

They could undertake well-baby clinics and family planning advisory work; or they could take a general practitioner's surgery and home visits regularly on one or two mornings a week. In participating in such activities they would be helping to reduce the work caused by increasing list size and, at the same time, taking the necessary steps to maintain their professional skills and knowledge.

At present some general practitioners may feel reluctant to pay part-time assistants if they cannot recover the cost of the salary by an adequate increase in the permitted number of patients. It is important, therefore, that the alternative arrangements for remunerating general practitioners now under discussion between the Ministry of Health and the profession should be such as to encourage employment of women doctors in general practice on a part-time basis.

The public health services employed in 1962-63 approximately the same proportion of part-timers as whole-timers.<sup>21</sup> Although too high a proportion of part-timers among the medical staff might involve difficulties, there are regular jobs in which continuity of service personnel is highly desirable which could be done by part-timers particularly in schools and infant welfare clinics, in the growing mental health and geriatric services and in population screening for such conditions as cervical cancer. Measures need to be taken to see that the part-timer in any such service is not isolated from her professional colleagues but is brought into the discussion of the current problems of developing the services.

#### MAINTAINING SKILLS AND KNOWLEDGE

Finally, even if steps are taken effectively to increase the number of part-time opportunities and to ease domestic difficulties by the provision of communal child-minding arrangements by potential employers or the local authority, there will always be some women who cannot or do not wish to take advantage of such arrangements and who will withdraw from active work for a few years while their children are young. These women should be encouraged (perhaps by such incentives as reduced subscriptions) to retain their membership of professional organisations, to read the journals, to attend scientific meetings arranged in the area and

<sup>21</sup> The public health service employed 19 per cent of the whole- and 21 per cent of the part-timers.

to visit the local hospital in order to participate wherever possible in ward rounds or case conferences.

General practitioners should also be encouraged to invite their women colleagues to sit in on surgery consultations and accompany them on their home visits. General practitioners might find that they benefit from the voluntary help which could result from encouraging such contacts. They would also be making a substantial contribution to the continuing education of those who will thus feel more confident to return to whole- or part-time professional work when their domestic commitments are reduced.

There is also a need for refresher courses for those doctors who have been out of practice for some years. Nearly all the women in this situation who responded to the inquiry indicated that they would welcome an opportunity to attend such courses. Recent schemes undertaken by various professional and administrative bodies in different branches of the health services to provide a variety of courses aimed to keep professional workers in close touch with current developments are to be welcomed from the standpoint of women as well as men. However, it is important for bodies providing courses to be in touch with potential attenders so that the maximum use is made of the education facility provided.

Finally, although much can be done by employing units to help medical women to exercise the professional skills they have acquired, ultimate responsibility rests with the women themselves. In accepting one of the limited opportunities for training for a profession whose skills are greatly in demand, they incur an obligation to the community which they must do their utmost to discharge.

## APPENDIX

### The Questionnaire

- Tables:* A1 Comparison of the ages of respondents and non-respondents.  
A2 Comparison of the periods of qualification of respondents and non-respondents.  
A3 Comparison of the occupations of respondents and non-respondents.  
A4 All respondents number and per cent by marital and maternal conditions.

## QUESTIONNAIRE

No:

All answers are treated in strict confidence and need not be signed with your name.  
PERSONAL PARTICULARS (please tick whichever answer applies).

- 1 Married..... Single..... Widowed or Divorced.....
- 2 Date of Marriage .....
- 3 Age .....
- 4 Number of children: 0..... 1..... 2..... 3..... more than 3.....
- 5 Children—any under five years old..... None under five years old.....
- 6 Date of qualification.....
- 7 Any higher degrees or diplomas in:  
Surgery..... Medicine..... Obstetrics.....  
Public Health..... Industrial Health..... Other qualification.....
- 8 If married: Is your husband a doctor?.....  
Does he approve of your working?.....
- 9 District lived in (Town and County).....

### PARTICULARS AS TO MEDICAL WORK (please answer yes or no)

- 10 Are you at present employed as a: (please tick which applies)

	Full-time	Part-time
Consultant	.....	.....
Junior House Officer	.....	.....
Senior House Officer	.....	.....
Junior Registrar	.....	.....
Senior Registrar	.....	.....

S.H.M.O.	.....	.....
G.P.	.....	.....
Public Health	.....	.....
Industry	.....	.....
Miscellaneous	.....	.....
Universities	.....	.....

- 11 If you are in part-time work:  
 Is it regular.....  
 Does it occupy more than 50 per cent of your time?.....  
 more than 25 per cent.....  
 Could you do more if it were available?.....
- 12 If you are not working:  
 Do you wish to work?..... If so, part-time?..... full-time?.....  
 If you wish to work, why are you unable to now?  
 Is domestic help too expensive?.....  
 Domestic responsibilities?.....  
 Lack of domestic help?.....  
 Lack of suitable part-time work in your own specialty?.....  
 Lack of regular part-time work?.....  
 Lack of full-time work with regular hours?.....
- 13 Is it financially worth while for you to work?
- 14 How many years did you work after qualifying? Full-time..... part-time.....  
 What type of work?.....
- 15 If you are not working would you find a postgraduate course helpful before starting again?.....

*Issued by the Medical Practitioners' Union.*

## CORRIGENDUM

TABLE A2 *last line should read*

1955 or later	23·7	26·3
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TABLE A1

Comparison of the ages of respondents and non-respondents

<i>Year of birth</i>	<i>Respondents Per cent</i>	<i>Non-Respondents Per cent</i>
1904 or earlier	13·8	19·4
1905-09	5·4	4·4
1910-14	8·2	7·7
1915-19	11·3	9·9
1920-24	16·7	14·0
1925-29	19·0	18·7
1930-34	15·6	15·7
1935 or later	10·0	10·2
	100·0	100·0

TABLE A2

Comparison of the periods of qualification of respondents and non-respondents

<i>Year of qualification</i>	<i>Respondents Per cent</i>	<i>Non-respondents Per cent</i>
1924 or earlier	7·0	12·3
1925-29	6·9	6·5
1930-34	5·3	3·9
1935-39	8·5	8·0
1940-44	12·9	10·5
1945-49	17·6	14·8
1950-54	18·1	17·7
1955-60	23·7	26·3
	100·0	100·0

**TABLE A3**

Comparison of the employment of respondents and non-respondents

<i>Employment</i>	<i>Respondents Per cent</i>	<i>Non-respondents Per cent</i>
Hospital service <sup>1</sup>	22.6	19.9
General practice <sup>1</sup>	28.9	7.7
Public Health <sup>1</sup>	16.4	12.3
Other <sup>1</sup>	13.4	34.7 <sup>a</sup>
Not working	18.7	25.4
	100.0	100.0

<sup>1</sup> The numbers of appointments have been reduced *pro rata* to equal the number of doctors.

<sup>a</sup> Includes doctors whose occupation is not known.

**TABLE A4**

All respondents: number and per cent by marital and maternal condition

	<i>Number</i>	<i>Per cent</i>
All respondents	8,209	100.0
<i>Married</i>	5,307	64.6
No children	1,032	12.5
1 child under 5	525	6.4
1 child not under 5	397	4.8
2 children some under 5	694	8.5
2 children none under 5	826	10.1
3 children some under 5	539	6.6
3 children none under 5	664	8.1
4 or more children some under 5	300	3.7
4 or more children none under 5	330	4.0
<i>Widowed or divorced</i>	457	5.6
No children	140	1.7
Some children	317	3.9
<i>Single</i>	2,437	29.7
Not stated	8	0.1

