Vrouwelijke huisartsen, een slag apart? : toetreding en participatie van vrouwen in de huisartsgeneeskunde
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Summary

‘Female general practitioners, a class apart? Women’s entry and participation in general practice.’

Introduction and research questions
In the last decades of the 20th century the number of female medical students increased steadily.
Currently there are more women than men graduating in medicine. It is even being referred to as a feminization of medicine, meaning a numerical increase of female physicians. In general practice the percentage of women increased from 4% in 1973 to 30% in 2003.
However, not everyone welcomes this development. Women are assumed to be less committed. They work part-time more often, which is undesirable if a shortage of general practitioners is imminent. One fears that the status of the profession will drop. But is this concern reasonable?
To answer this question we carried out a qualitative study. Information was gathered by means of a search of the literature and through interviews with female and male general practitioners (GPs).
The central research question is:
How did the entry of female physicians into medicine and general practice proceed, is the new generation of female GPs a ‘class apart’, and how do they participate in general practice?
On the one hand, the aim of the study is to record an important historical development, and on the other, if we find that the young female GPs have a different position in the profession and do not participate fully, to supply possible explanations for this and to discuss how to increase their participation. For it seems that women’s march into medicine can no longer be stopped, and they are badly needed to qualitatively and quantitatively safeguard professional practice.

Part I – Literature study: introduction, research questions and methods
We reviewed the literature from 1973 – the year in which the vocational training for general practitioners started – till 2003, the beginning of this study. The specific research questions are:
How did the entry of female physicians into medicine, in particular general practice, proceed in this period? Which developments in society and medicine/general practice played a role in the increase and position of female GPs? What changes can be noticed in general practice and are they related to the increase in numbers of female GPs?
We searched the general Dutch medical journals because it was here that we expected to find most publications on the feminization of medicine. We also searched the references lists of relevant articles in order to find other articles or books.
The developments in society, in medicine, and concerning women in medicine are recorded per decade. This makes it easier to oversee the developments, as well as enabling a comparison to be made with Becker’s theory on generations and their characteristics.

In the period from 1973 till 1982, it was the women of the Silent Generation (born 1930-1945) and the firstborn of the Early Baby Boom generation (born 1946-1955) who practised or entered the profession. In the 1983-1993 decade it was the women of the Early Baby Boom generation, but also the firstborn of the Late Baby Boom generation (born 1956-1970). In the last decade (1993-2002) the women of the Late Baby Boom generation and the first of the Pragmatic generation (born 1971-1980) entered the profession.

Results of the literature study
After World War II, in the period before the first decade of this study (1973-1982), hard work was the norm, it was a time of scarcity and material wealth was not common. The family was the cornerstone of society: the husband earned the money and the wife cared for the family.

The first decade was characterized by a dramatic change in society due to the Democratization movement and the Second Feminist wave. Equal opportunities for men and women was the motto. Women’s participation in labour increased. The ideal of the man as the sole breadwinner and the woman who did not have to work was abandoned. More and more girls benefited from middle and higher education.

In this period there were twice as many male medical students as female students. Also inspired by the women’s movement, the authority of the doctor started being questioned, the doctor-patient relationship needed to become less hierarchical.

General practice developed and acquired a central position in health care: the GP was the gatekeeper for specialist medicine.

The profession was still practised in the traditional way: solitary, own practice at home, often with the partner as assistant, who would stay at home when the doctor was on call. For a female GP it was not easy to find work in those days. Not only was she responsible for the housekeeping and the family if she had children, but there were also financial obstacles. It was practically impossible for women to borrow money to buy a practice, while being employed as a GP was a rare occurrence.

In the empirical study we found that the women of the Silent generation who practised in those days, either set up their own practice and built it up step by step, or became an assistant to a GP working on his own for one or more days.

In the second period, 1983-1992, employment levels in general dropped, as they did in medicine. The government strives for economic independence of men and women and the redistribution of labour. Women generally work part-time and the higher-level positions are largely occupied by men. The
work ethic changes, work is no longer the only thing that matters in life, leisure time is also important.
The number of women who start their medical studies exceeds the number of men.
General practice prospers, the first Standards are presented, and vocational training is extended from one year to two. For women it still was not easy to practise, especially in these bad economic circumstances. Because male physicians were also unable to find work as a GP, they joined forces to realize part-time work and a reduction of practice size. But female doctors themselves, united in the VNVA (the society for female physicians), also fought for the repeal of several obstructive regulations in the areas of law, taxes and insurances.
The ‘Vrouwenhulpverlening’ (women’s care provision) movement started to advocate more female GPs and gynaecologists because they were considered to have specific expertise necessary for providing better health care for women.
The female GPs of the Early Baby Boom generation had a somewhat easier start, but the standard remained being self-employed. Alternatively, if your spouse was a GP, you worked together in a practice.

In the last period, 1993-2002, women no longer lagged behind in education. Many women are employed, but mostly part-time. In the Netherlands the usual model is the ‘one and a half breadwinner’: the husband working full-time and the wife half-time. The economy starts to improve. Studying medicine becomes popular among women, while men seem to lose interest.
At the end of the 20th century the prospect of a shortage of doctors looms. Working part-time is considered to be partly responsible for this. Working hours have been reduced for residents, which already is causing problems, and on top of that part-time working is becoming more popular. This is a sensitive issue for the established physicians. On the one hand the problem is a logistic one: how to fill the duty roster. But concerns are also being expressed about dedication and involvement: how can you be a good doctor if you are only working half the time? Although the altered work ethic is probably ‘the source of evil’, in debates it is the female doctors who seem to get the blame. Resistance gradually decreases in this period and solutions are considered like shortening the training course, reshuffling duties, adjusting the organization of work. But a cultural upheaval is certainly needed. Work pressure in general practice is increasing, the established GPs are not satisfied with their remuneration, the gatekeepers role is being questioned, the younger generation wants to work in a different way, no longer on their own, but rather in cooperation with others. ‘Women’s health care’ now is called gender-specific health care. A lot of
research is being done on the subject of sex differences in practice and sex differences in illness and health. Medicine is becoming feminized in terms of numbers, but in practice the horizontal and vertical sex segregation has not yet disappeared. The self-evident male and female role patterns play an important part here. For instance, in a number of specialisations the percentage of women is still very low and women do not hold many influential posts in administration or management. More women are working in the specialisations in which fairly normal working hours are common, like general practice. They combine caring duties at home with practising as a doctor. The first women of the Late Baby Boom generation were faced with an adverse labour market and only settled down into general practice via roundabout routes. The choices available for this generation in terms of working arrangements have increased and this also applies to the next generation – the Pragmatic generation – that starts working at the beginning of the 21st century.

**Conclusions of the literature study**

In answer to the research questions, one can state that the entry of female physicians into general practice in the period 1973 till 2002 has been accelerated and gradually facilitated by developments in society. Laws were amended to realize equal rights for women and men, the breadwinner principle has been abandoned, fiscal measures were introduced to facilitate economic independence for men and women. The participation of girls in education increased. Part-time work and training became a right in the Netherlands. The work ethic changed, men also demanded more leisure time. Caring duties still are the responsibility of mothers, but fathers, more than before, are taking on some of the duties. An increase in demand for GPs and a change in the way of practising, which resulted in part-time work and training, and paid employment being available on a larger scale, also helped. The VNVA played an important role in eliminating hurdles specifically applicable to women. All these developments made it possible for the number of female doctors to increase, and greatly improved their position in professional practice.

The different generations of female physicians experienced more or less the same developments in comparison with other Dutch women, as characterized by Becker. A paid job was not common for women of the Silent generation with small children, but female physicians have always made more use of their training than other women. The women of the Early Baby Boom generation were the most active in changing their life course by combining family and work. The Late Baby Boom generation aimed at a better balance between work and private life, and the
Pragmatic generation is entering a labour market which has a strong need for young workers as a result of economic recovery.

The traditional ‘male-focused’ way of practising has changed, especially as a result of the altered work ethic and the work pressure experienced. As a result, it is quite possible to practise the profession in combination with other duties. The increased number of women has possibly played a role in speeding things up in areas such as part-time vocational training and part-time working.

As a rule, the caring duties at home still are the responsibility of the female GP. This means that she generally does not work full-time.

So women are participating increasingly in general practice, but whether the professional culture has been influenced as a result is questionable. In a ‘male’ professional culture for example, part-time working and interrupting one’s career is viewed as a sign of being less committed to your job, and that still seems to be the issue. Also, a proportional representation of the sexes has not yet been realized in the ‘higher’ regions of general practice.

Part II – Empirical study: introduction, research questions and methods

In the literature study we found no evidence that general practice thrives any less through the growth in the number of women, and neither does a shortage of general practitioners appear to be imminent.

Nevertheless the feminization is a cause for concern. Is this a generation problem or does it have something to do with the fact that women will soon be dominating the profession? What can be observed among general practitioners themselves? Are the young female GPs of today different? Are essential values of the profession disappearing as all these female GPs enter?

In an attempt to answer these questions, we performed an empirical study.

A qualitative research method was chosen.

The specific research questions are:

Is there a difference between the young generation of female GPs and her older female colleagues or male GPs in terms of the choice of, and passion for, the profession and the way of practising, and concerning their ambitions and their views on developments? If so, in what way?

We aim to gain a complete view of the various reflections and ideas concerning division of time between labour and care responsibilities; choice of, and attractiveness of, the profession; the way of practising (form and content); ambitions and developments in the profession; and of the central notions concerning these.

In order to answer the research questions we gathered data by means of interviews in which the topics were determined beforehand. Of the four different generations of Becker 3 to 4 female and about as many male GPs were interviewed, 26 practising GPs in total, from a sample of the NIVEL (Netherlands Institute for Health Services Research).

To get a clearer view of the unattractive aspects of the profession, it seemed
appropriate to interview some GPs who had prematurely stopped practising. From the same two generations (Early Baby Boom and Late Baby Boom generation) an equal number of GPs who had stopped prematurely (f/m) and practising GPs (f/m) were interviewed. This made it possible to compare them. The interviews were coded and analyzed. A fellow researcher also coded a number of interviews. The code systems were compared and appeared to correspond fairly well.

For each main question and sub-question, a summary of the results was made. The differences and similarities were analyzed from the point of view of: does the young generation of female GPs differ from the older generations of women and/or from the generations of male GPs?

Results of the empirical study
The young female interviewees talk with great enthusiasm about their profession. For them, work means being useful and appreciated. They do not differ from their older colleagues concerning how they made their choice. They find the same aspects attractive: long-term contact with patients, varied and all round work, being one’s own boss. That makes the profession so attractive compared with working in a hospital. Patient care is their most important ambition, ahead of teaching, but they do not find research attractive. In these aspects too, they are no different from their colleagues. Duties in administration or management are not popular with the young women interviewed. The older female GPs do not like these either, but they do believe you cannot ignore these tasks.

The younger generations of women and men differ from their older colleagues (f/m) in how they want to practise: not fulltime and preferably in cooperation with colleagues and other disciplines. Actually, among all interviewees, there appear to be only a few who still work full-time. The ones who are employed want to become self-employed in the future. If the young female GPs have (young) children, they are usually the ones who bear responsibility for childcare, but regarding this aspect they do not differ from their older female colleagues. However, it seems that the younger ones, more than the older ones, organize their work in such a way that it fits around their family responsibilities. Among this group of interviewees, we did not find that the young women chose the profession because it is easy to work part-time.

The ones who stopped prematurely had various reasons for doing so, e.g. not being able to find a practice, the kind of problems one encounters in general practice, and the severity of the job. This last aspect tipped the balance for some of the women who had stopped prematurely: they were not able to combine the job with family duties.

Concerning how they regard developments in general practice, the young female GPs, together with the men of their generation, differ in some aspects from their older colleagues. This is mainly related to the way the profession is practised: part-time work and the phenomenon of the ‘duty post’. The young
GPs (f/m) think it is also possible to be a good doctor this way, but the older GPs are afraid that part-timers feel insufficiently responsible and that the quality of care decreases with the introduction of the duty posts. All interviewees agree upon the professionalism and increased quality of general practice. They also share an aversion to the growing bureaucracy and administrative duties; it feels to them like an impairment of their professional autonomy. For some of the GPs (f/m) who had stopped prematurely, these kinds of things caused them to stop altogether, or to find employment. Some women of the older generations are concerned that what they prefer doing – ‘doctoring’ – becomes undermined by the bureaucracy, task delegation, and the power of the health insurance companies. Although it is generally thought not to matter whether a GP is male or female, all those interviewed believe there are differences in communication, ability to act decisively, considerateness, resoluteness. The general opinion is that it is a good thing that there are male and female doctors so that a patient can choose. A few young female GPs view this as a problem, as they do not want to treat just a selection of the total patient spectrum in surgery, they want to stay all round. The increased numbers of women entering the profession is associated particularly with part-time working. Regarding this matter opinions differ. ‘Hopefully they will take their responsibility’, seems to be the attitude of especially the older generation (f/m). Some young women would prefer not to have too many women entering the profession, so that the male-female ratio remains balanced.

Conclusions of the empirical study
The question: ‘Is the younger generation of female GPs a ‘class apart’ compared with her older female colleagues or with male GPs?’ should be answered with a ‘No’ based on these interviews. With regard to what they do, what they consider important, how they regard certain developments, what their ambitions are, the young female GPs in this study do not differ essentially from their older female or their male colleagues. They also cherish important values in the profession. So, also on account of the empirical study, the concern about involvement or dedication does not seem justified.

Strengths and limitations
The study of the literature is limited to the Dutch situation. A summary is given of the way in which female doctors/GPs were described in Dutch books and journals during a 30 year period. In the empirical study we tried to guarantee maximum reliability and validity through:
• not applying any selection in recruiting the interviewees, other than the fixed criteria;
• gathering information till saturation point was reached;
• interviewing in a uniform manner and recording the interviews on tape;
• using a qualitative computer program in order to enable other researchers to be involved in coding and analyzing the data.

However, whether one really ‘measures’ what one wants to ‘measure’ is a difficult question when attitudes and experiences are involved, and which – on top of that – often concern events that occurred in the (distant) past. Additionally, in open interviews a recency effect cannot be excluded.

Final discussion
A notable issue in the empirical study, however, is that the interviewees themselves also express concern about the increase in numbers of women entering the profession. ‘They don’t feel responsible enough; they do it on the side.’ Where does this concern originate from?

Maybe it is partly a generation difference. The older ones experience a change in the way the profession is being practised nowadays as a result of the altered work ethic, and they are afraid that this harms patient care. But, judging from what the interviewed young GPs say, one cannot conclude that they are practising the profession ‘on the side’. So at most you might say that there is a generation difference in availability, but not in involvement. Does a gender difference then play a part?

As a rule, women with children are faced with a dual responsibility: a care responsibility and a work responsibility. We also saw that the young generation female GPs, influenced by the changed work ethic, rather tend to adapt work around family responsibilities than the other way round. Although in general practice the way the profession is practised has changed, the professional culture still has a ‘male’ quality. This means that professionals are being judged according to standards that are valid in such a male-dominated culture. A dual responsibility does not fit in such a culture. Work should be priority number one and come before everything else. Someone with a dual responsibility cannot guarantee this. So an increase in the numbers of women is experienced as a threat to the continuance of the profession and its culture.

In other words, it could well be that the older generations of GPs consider that the young female professionals do not fit in the professional culture. This means that they are not accepted as full members of the profession. In this way no justice is done to, and inappropriate use is made of, their dedication and qualities. This applies even more to the so-called ‘hidha’s’ (GPs employed by other GPs), because they are sometimes fully excluded from the profession.

So, full participation of women in general practice is hindered by two obstacles: the self-evident way in which mothers have care responsibilities at home, and the ‘male’ professional culture in general practice, where work comes first. These obstacles have to be eliminated if full use is to be made of what women have to offer.
With regard to the first issue: this appears to be a persistent phenomenon, in which prevailing notions on what is good for children and who is best suited to raise children play the most important part in maintaining the status quo, namely that mothers keep doing what they do: taking the responsibility for childcare. The young generation of men and women have to voice their demands more strongly for work to be adapted to having a dual responsibility, so that fathers and mothers can combine their caring duties with work.

Also, the professional culture can obviously not be changed so easily since, despite the huge influx of women, the culture still is male-dominated. A change has to be brought about by the young generation of women and men themselves. In this profession it is well possible to realize work-care arrangements in which everyone’s personal situation in a certain phase of life is taken into account.

The established professionals have to ensure that young professionals get involved – and stay involved – in the profession, even when they take a temporary step backwards. Young women will have to follow their own chosen course and practise in a way which suits them, so that their qualities and talents become more visible. They have to introduce their ‘female’ values and norms into the professional culture. By now the female ‘minority’ in the profession has grown sufficiently to affect the professional culture. Also, among the professionals, there are enough female GPs with the ambition and talent for research and administration, who will be done justice when career scenarios are developed that are aligned with the life course of young people. In short, the time has come for the young generation of professionals, together with the established ones, LHV and NHG (the Dutch societies of GPs), to begin to move and set out a course to meet the consequences of the altered composition of the professional group, of the changed work ethic and of the wishes of parents to combine work with caring duties.

Recommendations for future research
Due to the explorative character of this study, findings cannot be generalized to the whole population of GPs. Future research might provide insight into the extent to which the differences and similarities occur. Reasons given by young GPs for not practising after completing their vocational training could be another subject of study. Finally, it would be interesting to establish whether the results concerning the professional culture also apply to other specialisations and professions.