

Original Article

WORK OF FEMALE RURAL DOCTORS

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ABSTRACT

Objective: To identify the impact of family life on the ways women practice rural medicine and the changes needed to attract women to rural practice.

Design: Census of women rural doctors in Victoria in 2000, using a self-completed postal survey.

Setting: General and specialist practice.

Subjects: Two hundred and seventy-one female general practitioners and 31 female specialists practising in Rural, Remote and Metropolitan Area Classifications 3–7. General practitioners are those doctors with a primary medical degree and without additional specialist qualifications.

Main outcome measure: Interaction of hours and type of work with family responsibilities.

Results: Generalist and specialist women rural doctors carry the main responsibility for family care. This is reflected in the number of hours they work in clinical and non-clinical professional practice, availability for on-call and hospital work, and preference for the responsibilities of practice partnership or the flexibility of salaried positions. Most of the doctors had established a satisfactory balance between work and family responsibilities, although a substantial number were overworked in order to provide an income for their families or meet the needs of their communities. Thirty-six percent of female rural general practitioners and 56% of female rural specialists preferred to work fewer hours. Female general practitioners with responsibility for children were more than twice as likely as female general practitioners without children to be in a salaried position and less likely to be a practice partner. The changes needed to attract and retain women in rural practice include a place for everyone in the doctor's family, flexible practice structures, mentoring by women doctors and financial and personal recognition.

KEY WORDS: family and work, female rural doctors, hospital practice, practice structure, rural medical practice, workload.

INTRODUCTION

Doctors are under-represented in rural areas and women doctors are currently less likely to go into rural practice than their male colleagues.^{1,2} Women now comprise nearly half the graduating medical students in many developed countries.^{3,4,5} This changing sex ratio of doctors, and the different way women and men contribute

to medicine, is compounding the maldistribution of doctors between urban and rural practice that has been identified as an important equity and workforce issue in many countries.^{6–8}

Rural medicine is the point in the profession where the changes stemming from the presence of women are being felt most fully and several papers have analysed the evidence for an emerging cultural change within the rural medical workforce.^{9–14} More than 60% of young doctors training for general practice in Australia are women.¹⁵ Workforce planners, medical educators and rural communities need to understand how these young women relate to their profession in order to attract them into rural practice.

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AIM

The aim of this research was to establish the evidence necessary to underpin the development of programs that support the recruitment and retention of women doctors in rural Victoria. This article concentrates on findings related to the interaction between family and work and the changes needed to attract women to rural practice.

METHOD

In 2000 the rural workforce agencies of New South Wales and Victoria identified the need for data about women rural and remote doctors to inform their educational and support programs. The NSW Rural Doctor Network carried out a mailed survey of all its women members.¹⁶ The survey was based on previous research by Tolhurst *et al.*¹⁷ and replicated in Victoria in 2000, Queensland in 2001 and Western Australia in 2002.¹⁸⁻²⁰ The themes explored concentrated on the interaction between personal and professional responsibilities, type of practice, reasons for choosing rural practice and changes needed to recruit and retain women doctors in rural practice.

The survey was a census of women doctors in Victoria working in Rural, Remote and Metropolitan Areas (RRMA) 3–7 and listed on the AMPCo database.²¹ A manual search of the database confirmed their status of employment. Of the 327 general practitioner (GP) records generated, 271 were identified as being eligible for this study. Sixty specialists were identified and 31 of these were eligible for the study. Those who were not eligible were registrars, not rural, left the practice, or retired. The initial mail-out was followed 4 weeks later by a second mail-out to those who had not replied. Fifty-four percent of eligible GPs ($n = 141$) and 58% of specialists ($n = 18$) responded. The specialities represented were psychiatry, anaesthetics, pathology, rehabilitation/geriatrics/palliative medicine, anatomical pathology, obstetrics and gynaecology, ultrasound, paediatrics and ophthalmology.

Data were analysed with the SPSS (SPSS; Chicago, IL).²² Eight questions allowed for qualitative responses and these data were analysed using NVIVO (QSR; Doncaster, Victoria) qualitative analysis software.²³

RESULTS

Family status

The majority of the GPs were or had been in a marriage or marriage-like relationship ($n = 122$) and 12% ($n = 17$) described themselves as not currently in a relationship. Four of the 18 specialists were not in a relationship.

TABLE 1: Working hours

	General practitioners (mean h)			Specialists (mean h)		
	Clinical	Other	Total	Clinical	Other	Total
All doctors	27	9	36	36	12	48
Full time	38	15	53	48	15	63
Part time	21	6	27	24	10	34
With children	26	8	34	32	Missing data	

Nearly half the GPs were married to other doctors and 10% had a farmer for a partner. Most of the doctors were young and in their child-bearing years (69%, $n = 94$ of GPs aged < 45 years; 28%, $n = 5$ of specialists aged < 45 years).

Eighty six percent ($n = 120$) of the GPs had children and 66% ($n = 79$) of those doctors had the main responsibility for their care. Seventy-eight percent of specialists ($n = 14$) had children and half of them were responsible for their care.

Workload

Hours of work was explored as both ‘clinical hours’ and ‘other’ and the doctors were asked to indicate whether they were working full time or part time and if part time, was this for family reasons. Fifty-two GPs (37%) and nine specialists (50%) described themselves as working full time (Table 1).

WORKING HOURS

General practitioners worked a mean of 27 clinical hours per week and 36 h total professional work. Specialists worked a mean of 36 clinical hours and 48 h total professional work. Other professional work included practice management, hospital work, teaching and learning, working with Divisions of General Practice, home visits, research, emergency calls, administration and paperwork and medical journalism.

Eighty-four percent of GPs ($n = 73$) and 67% of specialists ($n = 6$) who worked part time, did so for family reasons.

On-call

Sixty percent of the GPs ($n = 83$) provided on-call clinical services (mean, 27). An additional 12 women provided call-as-required. If the non-respondents to the survey have similar work patterns, then women GPs in Victoria

provide nearly 4000 h per week of on-call cover for their communities. The mean for specialists was 48 h, four provided cover as required and four did not provide after hours services.

Many of the GPs cited lack of child care for after hours work as a major issue for them, particularly when called in after hours to their local hospital. One result of this was a refusal to undertake after hours work. There is a strong negative correlation (Spearman's rank correlation coefficient: 0.342) between having responsibility for children and the number of hours worked outside normal clinical rosters. Seventy-eight percent ($n = 32$) of GPs without primary responsibility for children provided after hours on-call services, compared with 45% of women ($n = 35$) with primary responsibility for children. Caring for children was not related to on-call for specialists. Thirteen of 14 specialists who provided after hours care also had children.

Satisfaction with working hours

Thirty-six percent of GPs ($n = 50$) and 56% of specialists ($n = 10$) would prefer to work fewer hours. Nearly a third of the GPs said they were working longer than they wanted to in order to provide sufficient income for their families.

Can't work any less clinical hours as I am the sole wage earner and need to make a living, but because I do a lot of counselling I make less money per hour than many colleagues.

What this paper adds: Women make up less than a quarter of the rural general practice workforce and an even smaller percentage of the specialist rural medical workforce. As a result their experiences are not well articulated in research on rural medical practice and their needs are not well represented in policies and programs for rural doctors. The incoming cohort of rural general practitioners has a majority of women and it is essential that the practice styles and needs of women doctors are understood in order to attract and retain women in rural medicine. This survey identifies some of the effects of family responsibilities on the work practices of female rural doctors and the changes needed to the structure of rural practice to include the way women work.

The next most important pressure was the patient load and shortage of doctors, particularly female doctors.

Too many patients to see – I could work 8 days a week and still not fit them all in

Only 44% of specialists ($n = 8$) in the Victorian survey were happy with their working hours. Two specialists said they worked longer than they wanted to for financial reasons and the others were responding to patient demand, the shortage of specialists and to avoid placing an undue burden on their colleagues.

There is even less support for specialists than generalists in rural medicine and an even higher burden of overwork than there is for GPs. One consequence is that more than half of the female specialists were either planning to leave their current practice in the next 5 years (22%, $n = 4$) or unsure if they would stay (33%, $n = 6$). In contrast only 13% ($n = 18$) of GPs were planning to leave, while another 19% ($n = 26$) were undecided.

Hospital work

A substantial majority of GPs (82%, $n = 114$) were working in towns with hospitals and 65% of respondents ($n = 90$) provided hospital-based medical care. The women provided a range of in-hospital services, including inpatient care and accident and emergency services. A small proportion of GPs also provided obstetric, anaesthetic and surgical services.

Female GPs were equally likely to provide hospital-based care whether or not they worked in towns with a hospital (Fig. 1).

All the specialists practised in towns with hospitals and 78% ($n = 14$) provided hospital-based services. A quarter of the women were the only specialist with their qualifications in town.

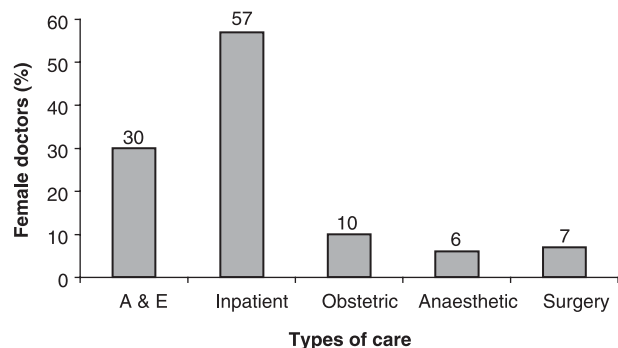


FIGURE 1: Percentage of female general practitioners providing in-hospital care. A&E: accident and emergency.

Practice type

Women work in a variety of ways in general practice. More than half the GPs were associates (37%, $n = 51$), partners (16%, $n = 21$) or intending partners (1%, $n = 2$) in their practice. Twenty-seven percent ($n = 38$) were salaried and four percent ($n = 5$) were there as locums. Some 15% ($n = 22$) were in another type of arrangement, mainly solo practice.

The high levels of responsibility women have for their families makes salaried work particularly attractive to women with young children, or women who are unable to make a decision to remain in one place because of the needs of their partner.²⁴ Female GPs with responsibility for children were more than twice as likely as female GPs without children to be in a salaried position and less likely to be a practice partner, independent of age.

Major issues

Major issues identified as facing female medical practitioners working in rural areas concerned a place for their children, including child care ($n = 73$), a place for their partner ($n = 53$), managing after hours commitments ($n = 32$), balancing work and family ($n = 24$), workload ($n = 19$), the need for flexibility in professional practice ($n = 15$) and lack of support from their male colleagues ($n = 14$).

The changes needed to recruit and retain female doctors in rural practice were identified. The major change suggested was in understanding that most doctors come with families and there must be a place for everyone in the family. This means a job for their partner and child care and schooling for their children. Single women have different needs, related to isolation and friendship.

Appropriate recognition was identified, including increased fees in recognition of the increased level of responsibility of rural practice, and the longer and more complex consultations demanded of women, and funding and tax deductibility of child care. Another aspect of this was the need to be valued for their work. It is a recurrent theme that women find themselves regarded as 'not proper doctors' because their style of practice in some ways does not mimic that of men.

Important changes were identified in relation to professional development and support. These included linking female medical students with female rural doctors, matching trainees with female mentors, adequate skill development in areas important to rural practice including emergency, anaesthetic, surgical and obstetric skills, and ensuring there is a career path in rural practice.

Seventy-eight changes were recommended to practice structure, including increases in the flexibility of rural practice, access to part time work, flexible working hours and on-call rosters, the possibility of job sharing and less commitment to after hours work, especially while caring for children.

The issues facing female rural specialists are similar in scope and different in detail to those facing female GPs. Family needs concerning a place for partner and children are the same although specialists are less influenced by them than GPs are. They seem resigned to heavy workloads and after hours work, although they would prefer it to be different. Specialists also sought flexible and local delivery of continuing professional development programs, similar to that available to GPs.

DISCUSSION

This research was based on women's experience of rural medicine. It is becoming clear that rural doctors are not homogeneous, and although they have more in common than they do differences in relation to rural practice, there are important issues in relation to workload and the intersection of personal and professional life for women that require immediate attention.

The fundamental issue identified in this research is the impact that responsibility for family has on clinical and other professional workload. Female GPs are highly likely to have the main responsibility for the care of their children and respond to this with a measurable reduction in clinical and other professional work, restriction of availability for on-call and after hours work and preference for salaried positions. They cannot be on-call for their practice and on-call for their family at the same time without support. This is true for half the specialists, but they are more likely to share the responsibility for the care of their children and to work extended hours in response to community need.

The changes needed to attract and retain women into rural practice have been identified in this research, and appear both modest and achievable. They include a place for everyone in the doctor's family, flexible practice structures, mentoring by female doctors and financial and personal recognition. Rural communities, workforce agencies and individual practices can draw on these findings to attract and keep women in rural practice. When female rural doctors are recognised as women as well as doctors, then the complexity of their lives and the subsequent need for flexibility will become self-evident and the basis for future workforce planning.

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