

Original Article

SUSTAINABLE RURAL PRACTICE FOR FEMALE GENERAL PRACTITIONERS

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ABSTRACT: *An expert panel of female rural and remote doctors have nominated updating professional skills as the most important strategy for sustainable rural general practice for women. The panel was comprised of members of the Australian College of Rural and Remote Medicine (ACRRM). The panel was asked to identify and prioritise strategies they had used to make rural practice work for them. They identified and ranked the following eight groups of strategies: (i) structure medical practice to work for you; (ii) implement personal strategies; (iii) obtain and update professional skills; (iv) establish professional and personal boundaries; (v) gain exposure to rural practice; (vi) engage with the community; (vii) implement professional strategies; and (viii) engage with women. Detailed strategies within these groups have been identified and will form the basis of grounded knowledge about how to structure rural and remote practice to work for women. This will complement the work of ACRRM, the Rural Doctors Association and workforce agencies in developing models of sustainable rural medical practice.*

KEY WORDS: *medical practice, rural medical workforce, rural, sustainable practice, women.*

INTRODUCTION

The present paper reports on a study to document the strategies used by female rural and remote general practitioners to enable sustainable practice. A total of 113 strategies were identified by an expert panel of female doctors.

More than half of young doctors training for rural general practice are female and women comprise more than 70% of the 2002 general practice rural registrar intake. This has profound implications for rural medicine. Several authors^{1–5} have identified an emerging cultural change among younger doctors within the rural medical workforce led by women. This change makes it urgent that we develop a systematic understanding of how women are engaging in rural practice in Australia.

WHY WOMEN?

Studies published by the Australian Medical Workforce Advisory Committee 1998,⁶ Australian Institute of Health

and Welfare 1996⁷ and the Department of Human Services and Health 1995⁸ have documented the increasing participation by women in the medical workforce and their relative shortage in rural medicine.

The Australian Medical Workforce Advisory Committee has produced two major reports on issues for women in medicine. The 1998 report⁶ found that: (i) of the 7235 clinicians in rural and remote areas, 1614 (22.3%) were female; and (ii) in 1995, 27.2% of the medical workforce was female.

The report confirms the underrepresentation of women in rural medicine. It notes that male and female practitioners participate in the medical workforce differently and that female doctors bring with them distinctive values, interests and work practice preferences. It recommends that AMWAC continue to monitor trends in medical workforce training and explore innovative approaches to participation and retention.⁶

The Brennan report on Trainee Selection in Australian Medical Colleges⁹ also found that the recent presence of women in large numbers in the medical workforce will have a profound effect on the workforce and the culture of the workplace. It recommended that ‘... employers and Colleges need to come to grips with this reality and not

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simply assume that the past, male dominated system will somehow adapt to the new order' (p. 67).⁹

The 1998 General Practice Strategy Review report *Changing the Future Through Partnerships* considered the question of women in rural medical practice and found that '... a growing number of female graduates would like to make a contribution to rural practice',¹⁰ but that their experience has not always been positive. The report identified two particular problems: (i) organisational arrangements are not sufficiently flexible to accommodate their lifestyle needs; and (ii) they experience additional difficulties to do with social attitudes and notes that these problems are well documented in the Australian College of Rural and Remote Medicine (ACRRM) Prospectus.

The report of the Ministerial Review of General Practice Training, *The Way Forward*, also draws attention to the need to systematically consider issues for women in medicine. It '... applauds Monash University's work on undergraduate curriculum processes dealing with female rural general practitioners' needs' and states that a strategic approach across the education continuum is required.¹¹

Recommendation 10 of the Ministerial Review of General Practice Training reads:

The Review Group recommends that the proposed National Council for General Practice Education and Training advise on strategies to meet the education and support needs of current and prospective female rural general practitioners.¹¹

The review also draws attention to the potential role of the ACRRM in ensuring relevant curriculum for female practitioners. The ACRRM's Prospectus¹² includes a section on Women in Rural Practice that has, as its objectives, the following: (i) to encourage women doctors to work in rural areas; and (ii) to encourage the development of patterns of practice in rural medicine that support and celebrate women medical practitioners.¹²

This is important confirmation that rural doctors recognise the need to address gender issues in undergraduate and postgraduate medical education and practice.

IDENTIFYING WOMEN'S EXPERIENCE

The National Rural General Practice Study¹³ conducted in 1996/7 (NRGPS) demonstrated that female doctors are satisfied with different aspects of rural practice compared with men. In that study, women were particularly satisfied with their family and social environment, peer support, physical location and non-clinical work, and these were the issues of least importance to the general population of

rural doctors. The National Rural General Practice Study also found that three of the four issues considered the least important in contributing to quality of life among all rural doctors (practising public health, availability of non-medical practice education, access to health care for your own needs) were rated as more important by women than men. That is, the small number of women makes it hard for their voices to be heard.

Data about the educational and support needs of female rural general practitioners have been collected and analysed by Tolhurst *et al.*,¹⁴ who also found that '... because a rural doctor tends to be male, the aggregate results of research into the needs of rural GPs tend to reflect the needs of male GPs'.

The recent study of female rural doctors in New South Wales by the NSW Rural Doctors Network (RDN)¹⁵ confirms this suggestion. McEwin also surveyed a sample of male rural doctors and compared their expressed needs with both those of women and those being addressed by the NSW RDN. She found that the programmes being implemented by the NSW RDN reflected the issues raised by the men, but not yet those raised by the women.

The reports by McEwin¹⁵ and a similar survey conducted for the Rural Workforce Agency of Victoria by Wainer¹⁶ have built on the work of Tolhurst *et al.*¹⁴ to articulate and rank the issues of importance to rural women doctors.

One of the conclusions from the Victorian female rural doctor survey was that the major struggle for women is to reconcile their multiple roles with workplace structures based on the assumption that the country doctor has a partner taking care of home life, or else has no home and family.¹⁶

Thus, the study reported here builds on a need identified by policy bodies for a more accurate understanding of female rural medical practice and a body of work that has started to articulate that practice.

THE STUDY

This is a descriptive study of the strategies used by women in sustainable rural medical practice using the Delphi technique. Ethics approval was granted by Monash University.

Delphi technique

The Delphi technique involves repeated rounds of communication with an expert panel, starting with an open-ended question to enable a wide range of responses and ending with consensus. It is a well-established research method designed to use the judgement of experts to provide scientific evidence in fields that have not yet

developed to the point of establishing formal scientific laws.¹⁷ It is a procedure for eliciting and refining group opinion and replaces direct debate with a carefully designed programme of sequential interrogations interspersed with information and opinion feedback. It is widely used within health research and is particularly suited to a widely dispersed group such as rural doctors.

The expert panel

The selection of the expert panel was done through cooperation with the ACRRM.

Welch *et al.*¹⁸ established that 80% of new information about health issues in a rural town could be obtained by interviewing seven key informants. Using this as a guide, between five and 12 women for each state and territory were contacted and agreed to take part in the Delphi round.

The expert panel comprised 36 women from rural and remote practice from all areas of Australia. Women were preferentially selected if working in small (population 1000–5000) rural and remote towns. They are core-researchers in the project, they hold the information and the researcher has the role of eliciting and reporting on it.

The women were sent a 15-item questionnaire that sought to locate them in their community, their practice and their family. Eighty-five per cent of the women were in a stable relationship, including one who identified herself as lesbian, 12% were single parents and one coresearcher was single with no children. Their ages ranged from 30 to 62 years and most were in their early 40s.

Twenty-eight women agreed to be part of a Female Rural Doctor Research Network.

Delphi first round

The purpose of the Delphi study is to identify the core strategies that comprise successful rural practice for women. The question asked in the first round was ‘What have you done to make practising rural medicine work for you?’ The open-ended question from the first round generated 113 strategies. The responses fell into a number of categories and these have been used for purposes of clarification and refinement and also to make the data manageable.

The qualitative analysis software Nvivo (Qualitative Solutions and Research, Melbourne, Australia) was used to generate reports of the number of responses in each strategy. This was developed into a convergence figure for each strategy that ranks them for internal coherence. The coherence rating was developed by dividing the number of strategies by the number of women who suggested them. Fewer strategies nominated by more women indicated greater coherence and, thus, the highest level of agreement.

Table 1 provides examples, in the words of the women, of the strategies used to make rural medical practice work for them.

The themes that came through strongly were the importance of being well prepared with the professional skills required for rural practice, the value of working in a practice environment that was flexible and compatible with the women’s other responsibilities and the importance of integration of self and family into the rural context. Almost all strategies were quite sex specific and unlikely to have been initiated by male doctors. The exception is the action taken to develop appropriate skills for rural medical practice. Male and female doctors do what they can to ensure they have these skills or adapt their practice to reflect the skills they do have. For example, one of the respondents undertook the following pathway to rural practice:

- Enrolled in and completed Early Management of Severe Trauma course during 3rd year post-graduation.
- Enrolled in and undertook a vocational training position in rural/semi rural general practice for 1 year. Sat and passed General Practice Exams. Then, moved directly to Rural X and became a partner in a practice being set up in a town with a long-standing doctor shortage. Have been doing this for 3 years and, in that time, I have done an Advanced Life Support course and an Advanced Paediatric Life Support course.
- Did a DA (Diploma Anaesthetics), followed by 5 years general practice anaesthetics; I would find that very hard to give up now.

The Primary Curriculum of the Vocational Preparation Program and the Professional Development programme developed by the ACRRM reflects the importance all rural doctors place on being well trained for the extended demands of rural medical practice.

The other strategies are more sex specific and reflect the complex lives women lead and their additional work as the main carers for their families. Sixty-five per cent of Victorian female rural general practitioners reported that they have primary responsibility for the care of their children and they are the doctors who work the least clinical and non-clinical hours (p. 15).¹⁶ The strategies identified by the women in the Delphi study reflect the innovative ways women manage this and, particularly, the importance of practice structures that respect their other roles and value their contribution to rural medicine.

Some women took on non-clinical work that was more predictable in hours, for example:

Ongoing modification of hours of work and after hours commitment to make life workable for me and my family.

This included reducing my clinical commitment to half-time from full-time and taking a half-time clinical job as associate medical editor of a medical journal.

The women searched for practice arrangements that suited their lives and their style of practice. Some were able to find this, while for others the only way to obtain this was to set up their own practice:

Negotiated with (life) partner who is/has been practice partner to share skills (e.g. he does obstetric deliveries/procedures and more complex procedural skills and I do more women's and mental health). This means I earn less in the practice but because we are in partnership this is not a problem so far.

Ensured that in my first year out I discussed, in depth, the issues of on-call, fair payment for work. I was lucky in that my first partner agreed to a 50% split partnership. Despite the fact that as a woman I tended to see more c + d consults and, initially, of course, I was slower than him, we still split the profits and costs 50%. We split the on-call evenly as well. Both of us could do anaesthetics, minor procedures and mids.

When the choice of practice proved to be wrong, particularly because of its inflexibility and refusal to provide adequate maternity leave, I had to decide where to go next and opted to start a practice of my own to develop the working environment I felt was required to offer the service I wanted to offer to patients as well as give me a sustainable lifestyle. This involved gaining business

TABLE 1: *Strategies and examples of the strategies used by women to make rural practice work for them*

Strategy	Examples given by women interviewed	Coherence rating
Obtain and update professional skills (126 examples)	Prepare for what you want to do; you can't go out half hearted and expect people to accept that you are capable. You have to show them Prepare for rural practice by upgrading skills (e.g. radiology skills, emergency medicine) that enhance confidence with after hour/on call work	0.84
Structure medical practice to work for you (84 examples)	3 days a week and on call one weekend in five; this gives continuity of care for patients, a great sense of ownership of work and some acute care to keep on the ball Chose a practice that will give flexibility in: (i) working hours/days; (ii) responsibility; and (iii) work agreement, no pressure to elevate from assistant to associate or partner	0.65
Implement professional strategies (83 examples)	Increase professional supports by attending women in GP activities run by the RACGP and becoming involved with Women In Rural Practice Committee of ACRRM Accept the significant help offered by Division phone calls, visits from senior members, lots of information	0.71
Implement personal strategies (46 examples)	Marry a rural GP Keeping fit and time out are essential	0.63
Engage with women (41 examples)	Bring up gender issues in as many fora as possible Work to change the rhetoric that 'super doc' is the only valued rural doctor	0.85
Establish professional and personal boundaries (28 examples)	Take 4–6 weeks holiday per year, leave the community and spend time as a family Be really firm about limits of availability, in time and personal space	0.61
Engage with community (13 examples)	Join in local community events/groups (e.g. Rotary, children's soccer, basketball club doctor, local acting group) Find other families with small children; this helps feel involved and committed	0.75
Gain exposure to rural environments (12 examples)	Train in Rural/Remote Base Hospital for first 2 years after graduation, gaining experience in anaesthetics and emergency medicine Bush experience for a taste of remote medicine	0.77

management and accounting skills ... and also isolated me professionally to a degree.

Flexibility in professional training and practice structures has been identified consistently as a major issue for female doctors.^{15,16,19} The women in the present study described the ways in which they skirted their way around inflexible systems. There were women who found a place that welcomed them both as doctors and as women, although for most women the compromises and flexibility had to come from them so they could fit existing structures. They did this by developing interests outside medicine, putting limits on their availability and learning from other women that the need to do so was a problem with the system, not with them:

Developed my interest in farming, winegrape growing and made friends in these industries as a diversion from the medical sphere.

Interacting with other female doctors was one strategy used to deal with the discomfort of working with a practice and personal style that was not validated in a rural context:

Learnt to avoid being a victim when male colleagues discriminate (bad in North Queensland) ... and learnt to be more assertive and operate outside my personal comfort zone.

Most of the women took it upon themselves to find ways to make an inflexible system with incompatible work practices acceptable, often with the help of friends and extended family, like the doctor who ‘... developed a supportive network of friends prepared to bail me out when baby-sitting, meals are required’.

The women identified many innovative ways in which they contribute to their communities by bringing in additional skills, particularly in mental and women’s health, and by working with Divisions of General Practice to develop self-care and trauma programmes for doctors and

public health initiatives. There is a sense of pride in these achievements and a quiet pride in the skills and attitudes they bring to rural medicine.

Delphi second round

In the second round, the expert panel was asked to rank the strategies they had identified in order of importance from 8 to 1, with 8 being the most important and 1 the least important (Table 2). This resulted in a different ranking from that shown in Table 1. Whereas the strategies identified most often by the expert panel were those relating to obtaining and updating professional skills, this was only the third most important of the strategies when ranked by the panel.

The number one strategy identified by the expert panel is that of structuring rural practice to include the way they work as women, followed by the implementation of personal strategies and obtaining and updating appropriate professional skills.

The next task for rural medicine is to develop sustainable models of practice for female and male rural doctors. The expert panel has identified practice structures as the place to start. Female rural doctors have implemented flexible hours, changed waiting rooms, patient information practices, structured communication with practice staff, cooperative working arrangements with male colleagues, shared on-call and time off after being on call, setting limits, building in time for paperwork, accepting help from Divisions and colleagues, working in salaried positions, scheduling appointments to leave time for emergencies and finding supportive professional and life partners.

The strategies of the women who were surveyed can be summed up by the remote area doctor who says sustainability for her is ‘... having goals and vision (light at the end of a tunnel), being flexible, especially with organisational changes and growth, and to retain a sense of humour’.

While individual women are developing individual solutions, the expert panel has identified the need for supportive practice structures as the most important

TABLE 2: *Priority ranking of strategies for sustainable rural practice for women*

	Practice structure	Personal strategies	Professional skills	Set boundaries	Exposure to rural environment	Engage community	Professional strategies	Engage with women
Mean	5.88	5.41	5.28	5.19	4.41	3.78	3.81	2.22
SD	1.98	1.66	2.04	2.19	2.72	1.86	1.82	1.77
Median	6	5	5	6	4	4	3.5	1.5
Mode	8	5	5	7	8	2	3	1

contribution to sustainable rural practice for women. This is the responsibility of the whole profession, not the individual woman.

It seems that the women are putting into place, for themselves, professional and personal structures necessary for sustainable rural and remote practice and that these can be appropriately supported by their professional organisations.

CONCLUSIONS

Female rural doctors find ways to work around the challenges of the job. They organise practice structures, skill themselves for the extended nature of rural practice, set limits and establish flexible work and complex family arrangements to enhance the dance between self, community, family and practice.

The evidence from the present study can be used to help existing medical practices to restructure so that they are attractive to women, rural communities to negotiate service agreements and support structures that will attract women, rural workforce agencies to ensure that their programmes of support are accessible and appropriate for female rural doctors and medical colleges to structure regional training programmes sensitive to the needs of women.

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