National Female Rural GP Research Project: Some Preliminary Findings

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ABSTRACT

Women currently account for 50% of the graduates from Australian Medical Schools and 60% of registrars in the RACGP training program. Female GPs, however, account for only 23% of GPs in rural and remote communities. The University of Newcastle is undertaking a qualitative research project to assist the Department of Health and Aged Care with the development of additional supports and incentives to attract and retain female GPs to rural and remote areas. Female GPs are being interviewed either individually or in focus groups in 12 Divisions of General Practice covering a range of geographical, demographic and practice types across rural and remote Australia. Interviews are also being conducted with a range of medical, rural and community organisations. Focus groups will also be conducted with female medical students and registrars. The project commenced in September 2000 and will report to the Rural Sub-Group of GPPAC in May 2001.

INTRODUCTION

Women, according to the AIHW, currently account for more than 50% of the graduates from Australian Medical Schools and for 60% of the current cohort of trainees in the Royal Australian College of General Practitioners (RACGP) training program. More than half (53.2%) of general practitioners less than 35 years of age are women with 62.8% of female GPs being under 45 years of age. Female GPs, however, remain under-represented in many rural and remote communities with considerable variability between the States and NT, between regions and different sized towns and communities.

Over the last decade, the Federal Government has introduced a range of initiatives designed to attract and retain GPs in rural and remote locations. These initiatives have included relocation assistance, training, remote area and locum grants, rural retention payments, family support and the establishment of the rural workforce agencies in each State and the NT. These initiatives have done little to address the maldistribution of female GPs between rural, remote and metropolitan areas. Recent research by the RDN in NSW suggests that these initiatives have basically addressed the needs of male GPs with very little attention being paid to the support needs or practice style of female GPs.

In their report to Dr Wooldridge in March 1998, the General Practice Strategy Review Group (GPSRG) recommended that specific attention was required to address the needs of female GPs in rural and remote areas, with Recommendation 59 stating:
That new strategies to support women rural GPs be developed at the individual, practice, local, State and Northern Territory and national levels, in health services and community environments to improve recruitment and retention of female GPs in rural areas.\textsuperscript{4}

Despite a number of additional initiatives to address other recommendations of the GPSRG, nothing specific has been announced in relation to Recommendation 59. In order to progress the needs of female rural GPs, the General Practice Partnership Advisory Council (GPPAC) in December 1999 endorsed a motion from its Rural Sub-Group to establish a Female Rural GP Working Party and for a National Female Rural GP Project to be undertaken. In July 2000 the University of Newcastle was contracted to undertake a national qualitative research project to identify

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  \item current support mechanisms in place to support female GPs in rural and remote communities;
  \item additional support mechanisms or incentives required to improve female GP recruitment and retention to rural and remote areas; and
  \item the types of workplace structure/practice arrangements in which female GPs prefer to work with a view to identifying sustainable models of rural and remote practice for female GPs.
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Work on the project commenced in September 2000 and will be completed by the middle of 2001.

**METHODOLOGY**

The research methodology for the project is of a qualitative nature, based on in-depth individual and focus group interviews with female rural GPs in a cross section of rural and remote Divisions of General Practice. The majority of interviews to date have been face-to-face interviews with individual GPs due to the difficulties of getting rural female GPs together in one place to do focus groups. A number of interviews have also been conducted by telephone with more remotely located female GPs, or with those who were not available when their particular Division was visited.

Up to 14 rural and remote Divisions of General Practice across Australia will be visited during the life of the project. The Divisions selected cover a range of geographical and demographic situations (inland and coastal rural; remote NT and WA; regional centre; off-shore island; Tasmanian Division) as well as a range of practice arrangements (solo/group, all female, full/part-time, salaried/contract/locum positions, registrars, outreach services, and OTDs/TRDs).

Interviews are also being conducted with the rural workforce agencies and State-based organisations in each State and the NT and with each Division of General Practice visited. Other organisations also being interviewed include the University Departments of Rural Health, the RACGP, ACRRM, RDAA, AMA, ADGP and State/Territory health officials.
Permission is sought from the female GPs to have the interview taped with the tapes then transcribed to enable their analysis by “Ethnograph v5.0 for Windows” — a program for the analysis of text-based data.

PRELIMINARY FINDINGS

Seventy individual interviews have been conducted with female GPs in 8 Divisions of General Practice across rural and remote locations in SA, NT, Tasmania, Northern Rivers of NSW, Southern Rural Division of Queensland and south-west WA. Approximately 120 interviews will be undertaken with female GPs in rural and remote locations by the end of April 2001. More than 20 interviews have been conducted with the respective State/NT RWAs and SBOs, the RDA, AMA, Territory Health Service, HCRRA and Divisional CEOs.

Demographic profile

Fifty-seven (82%) of the 70 female GPs interviewed are married or in a long-term relationship. Nine are single; two are sole parents and one is engaged.

Nineteen (or 33%) have partners who are a GP or specialist and 4 (7%) have partners who are other health professionals. Six (10%) are married to farmers and 9 (15%) are house husbands/primary carer although this was often not by choice but because of difficulties accessing employment. The occupations of the remaining partners included geologist, engineers, chef, park ranger, administrator and business person.

Forty-nine of the female GPs have between one and four children, 36 (74%) with children either under school age or at primary school. Nine who are married or in a long-term relationship have no children, and one is pregnant with her first child.

Twenty-three (33%) of the female GPs interviewed had either lived in a rural community during part or all of their childhood. Twenty-six (45%) of those in a long-term relationship or married have partners with a rural background. Many of the female GPs had followed their partners to rural and remote locations, while for many couples it had been a mutual decision to move away from the city.

Practice type

A definite preference for group practice was evident with 58 working in practices with more than three GPs. Seven worked in solo practices and 5 in two GP practices. Forty-two (60%) were in salaried or contract positions, of which 7 were registrars and one was a locum. Eighteen (25%) are practice principals (25%) and 10 are associates/assistants (14%).

Thirty-eight (55%) of the female GPs interviewed work full time, with three working across practices in two different towns. The remaining 32 work part time with the number of sessions varying from 2 to 8 per week. Many of those working part time do participate in on-call and the after hours rosters.

With the exception of minor procedures such as the removal of skin lesions and moles, injection of joints and hormone implants, the majority (56 or 80%) of the female GPs
interviewed did not do procedures. Nine indicated that they had obstetrics training but no longer used these skills either because of the cost of medical indemnity insurance, the local hospital no longer provided obstetrics services or because of the difficulties associated with the after hours and on-call when they have small children. A number of the female GPs interviewed indicated areas of special interest including women’s health, counselling, hypnotherapy, alternative therapies including acupuncture, skin cancer and sports medicine.

The length of time in rural or remote practice varied from 3 months to more than 27 years, with the period of time in their current location varying from 7 weeks to 25 years. Forty-five (65%) had previous general practice experience in a rural or remote location, many as registrars. Thirty-three (48%) had been in their current location for more than 5 years, and 20 female GPs had been in their current location more than 10 years.

With the exception of female GPs in remote areas of the NT, 29 of female GPs interviewed indicated that they would be staying in their current location for the next 5 years or the foreseeable future. The major reason for relocating to another area was their children’s education; partner’s employment or decision to move; health reasons; retirement; overseas travel or overseas medical practice (third world) or relocation to another rural or remote location. Those moving because of their children’s education, health or partner’s employment were usually moving to the capital city or a large regional centre. A number of the registrars interviewed were only fulfilling the rural term requirement.

**Major benefits of rural and remote practice**

General practice in a rural community has both professional and non-professional benefits according to the female GPs interviewed. The non professional benefits include a variety of lifestyle factors such as open spaces, fresh air, a safe and healthy environment for children, cheaper housing or opportunity to own a hobby farm, being close to the beach or the bush and proximity to work. Other non-professional benefits included being part of the community and good local childcare and primary schooling. These are not dissimilar to the benefits identified by male GPs in previous studies.

The major professional advantages of practising in a rural area were providing whole patient care with fewer referrals to specialists and the opportunity to look after patients in hospital. Other professional benefits included multi-generational family care; opportunities to combine both procedural medicine and population health; working in a multi-disciplinary team; and a supportive local Division. Many of the female GPs interviewed indicated that they did not want to work in metropolitan general practice because of the dominance of bulk billing clinics which were seen to devalue their abilities; progressively de-skill them; and undermine patient continuity of care.

The opportunity to work as part of a multi-disciplinary team in Aboriginal health was a major benefit of working in remote communities. Remote practice was also seen to provide the opportunity to work in a genuine area of need, where you could “make a difference rather than make a fortune”. A number of the female GPs in remote areas referred to a sense of personal fulfilment as well as challenge and adventure. Others
mentioned the opportunity to learn Aboriginal languages and experience cross-cultural issues in both the professional and non-professional lives.

**Major stresses for female rural GPs**

Female GPs in both rural and remote Divisions identified similar stresses or disadvantages. However, many stressed that the benefits and rewards of rural or remote practice outweighed these disadvantages.

The major factors identified by female rural GPs as undermining their commitment to rural practice included:

- a lack of opportunities for spouse employment in rural and remote areas;
- the negative attitudes of many rural male GPs and medical organisations to female rural GPs, particularly those working part time;
- the lack of respect for the practice and working styles of female GPs by male colleagues;
- problems with employment contracts/salaries including lack of access to superannuation and their portion of the Practice Incentive Payment;
- the stresses of balancing career and family responsibilities including the problems associated with childcare when on call or working after hours;
- social isolation with many female GPs referring to the “tall poppy syndrome” and the “goldfish bowl” mentality of rural communities;
- professional isolation with many finding the dual responsibilities of family and career and the inflexibility of training and education events limited their options for further or continuing education;
- lack of access to specialist services including publicly funded allied health services; and
- personal safety for on-call and after hours.

**Existing support mechanisms**

**Personal**

The single most important source of support identified by female rural GPs who were married or in a long-term relationship was their husband/partner. Many indicated that the emotional support offered by their partner was critical to them performing their role as a rural or remote GP. The importance of a close emotional relationship was further borne out in the interviews with single female GPs who expressed feelings of loneliness and social isolation, a situation made even more difficult when the female GPs had responsibility for small children.

Other important personal supports identified included other family members, close friends, other female GPs or health professionals and their Church.
Professional supports

Practice

The nature of the support provided to female rural GPs by their practices varied enormously and often reflected whether the female GPs was a practice principal, associate/assistant, salaried or on contract. Generally the support provided by the practice included a room, equipment and computer as well as access to practice staff and nurse.

Some practices, however, appear to have sought the maximum benefit from having a female GP but provided only minimal support in terms practice infrastructure (no room of their own — move from one room to another), financial remuneration, access to training or respect for their working styles. Many female GPs on a salary or contract, do not have access to superannuation, their portion of the Practice Incentives Payments, recreation or sick leave.

Many female GPs felt pressured to work longer hours and/or reduce the length of their consultations to improve the practice’s bottom line. This situation was not assisted by their lack of access to cases requiring shorter consultations or by community expectations that female GPs will have longer consultations.

Many female GPs resented the attitude that they had it easy because they worked part-time; or that the male GPs were “doing them a favour” sending them all their PAP smears. Many felt the practice benefited significantly from having a female GP, but that the emotional energy put into many of their consultations was not acknowledged financially, professionally or personally. Practices where there was more than one female GP were generally considered to be more supportive of women’s working arrangements and practice styles.

Practice arrangements which shared the on-call roster with other practices in the area were welcomed by most female GPs as this significantly reduced the stress of on-call, particularly for those with children.

Professional associations

On the whole, female rural GPs saw their Division of General Practice as the most supportive professional organisation for them. CME and family support weekend provided good opportunities for education and networking with other female GPs and their families. Specific divisional initiatives such as Women Doctors dinners, orientation programs and GP well-being weekends were also highly praised.

A number of female GPs were unaware of the rural incentives provided by the rural workforce agencies. This was particularly evident in the more coastal Divisions where information about relocation grants and other assistance was scant. Female GPs in remote or isolated inland Divisions were far more au fait with the supports offered by their RWA including relocation and remote area grants, locum and training support.

The majority of female GPs interviewed did not see the major medico-political organisations as sources of support. Less than 10% of the female GPs interviewed were members of the AMA. Many indicated that the AMA was too metropolitan focused and not really interested in general practice; that it was too conservative and elitist; and that...
its fees were too high. Some female GPs indicated that they had withdrawn their membership of the AMA because of their lack of support for young doctors over the restriction of provider numbers in the mid-1990s.

Membership of their State RDA was also low among female GPs, although there was some confusion between the RDA, the RDN, ACRRM and the Rural Faculty of the RACGP. Of those familiar with the RDA, very few saw it as supportive of them in their role as female rural GPs, some indicating that it was a “boys’ club”.

A significant number of the female GPs interviewed were members of the RACGP, with others making the comment that it was “essentially an ivory tower in Melbourne”. Others commented that they were only member because they had to be and that they would be moving to ACRRM when it was up and running. Generally the female GP registrars found the RACGP to be a good source of support in terms of mentors, training and financial assistance.

Local community, council or hospital supports

At the individual level, most female rural GPs interviewed referred to the close friendships they had formed in their communities usually outside the medical profession, often through church groups, sport or their children. A number of female GPs made specific reference to the social support provided by their local church when they moved to the area. Little or no support was offered at the community level or by community organisations such as Rotary or the CWA to welcome or orient the female GP and her family. The situation in remote Aboriginal communities was different with orientation and support provided through the RWA, the AMS and local Aboriginal community.

Community expectations of the roles of the female GP were seen by some of the women doctors interviewed to be unrealistic. One GP explained that “women doctors are still under pressure to conform to traditional role models in terms of community expectations”. For example, the community wants you to be always available which is consistent with the traditional model of the country GP, but at the same time you are also expected to fulfil the traditional role of wife and mother. Fulfilling these conflicting roles is impossible when the community supports you in neither. One female GP told how isolating it was when she went to work at the school tuck shop and the other mothers would not talk to her because they were in awe of her. Another sensed some prejudice towards her because of the perception in the community that she was rich.

Support from local Councils, in most cases, was limited to smaller more remote or isolated communities. For example in the Central Wheatbelt Division of WA, councils often provided free or subsidised surgery and house, as well as a car to GPs moving to these areas including OTDs. Many of the GPs in remote Aboriginal communities in the NT also had subsidised or free housing as part of their salary package. The standard of this housing had improved considerably over recent years, most being modern and air-conditioned.

Support from local hospitals depended on whether the GP was a procedural GP and participated in the on-call roster. A standard form of support provided by the hospital
was the provision of facilities to attend to patients after hours. This was a very important safety issue for many female GPs.

In summary the major supports for female GPs in rural and remote areas are

♦ partner, family, friends and church;

♦ Division of General Practice activities — CME, family support weekends, IMIT, population health projects, women’s dinners, GP Well-Being weekends;

♦ other female GPs in the practice or from other practices;

♦ other health professionals in the area — particularly remote area nurses in remote areas; and

♦ rural workforce agencies — locums, relocation and training grants.

Preferred type of practice

The majority of women expressed a desire to work in a group practice with at least one other female GP. Having another female in the practice meant that you didn’t do all the PAP smears and women’s health, as well as providing another female with whom to debrief. Many also indicated that it was better to work in a larger practice where the GPs in the practice could cover for one another when on leave rather than having to rely on locums. Most preferred to work part-time hours and have reduced after hours and on-call obligations while their children were young.

Only a small proportion have indicated that they want to be practice principals, preferring the flexibility of either being an associate/assistant or in a salaried or contract position. The complexity of the business management side of being a practice principal was a major disincentive for many female GPs, with the amount of time required impacting negatively on the family. The greater flexibility provided by salaried/contract positions also reflects that fact that many female GPs place their partner’s career before theirs, enabling easier relocation should this be required.

Additional supports suggested

Female GPs have suggested a range of additional incentives that would improve their recruitment and retention in rural and remote areas. These include:

♦ assistance with spouse employment, further education, retraining or access to business start-up packages;

♦ development of information packages, an advocacy service and training courses to assist female GPs in negotiating contracts and rates of pay for sessional/part-time employment including access to PIP, superannuation and leave arrangements;

♦ recognition and support for female GPs on maternity leave including priority for locum assistance, support for retraining and upskilling with the provision of childcare; and support through GP health and well-being initiatives for female GPs with young babies to reduce the stresses of returning to practice;
♦ the provision of childcare assistance for on-call and after hours work;

♦ more flexible training/retraining options for female GPs moving into rural general practice or returning to practice after a period out of practice (eg Birth of a child, illness);

♦ development of mentoring programs and support for new female GPs and registrars in rural and remote areas as well as assertiveness training and negotiation skills workshops;

♦ improved support for other rural health professionals such as nurses and allied health professionals working in rural and remote locations;

♦ better orientation programs for female GPs and their families moving to rural and remote communities;

♦ development of safety protocols for on-call, after hours and home visits (maybe by the Divisions);

♦ support for gender-based studies in all undergraduate and postgraduate medical courses so that the different practice styles and preferences of male and female GPs are acknowledged and respected;

♦ improved remuneration for longer consultations such as for depression and complex conditions;

♦ more flexible rural incentives to attract female GPs to rural areas including better information dissemination on current incentives — maybe through female GP liaison officers in the Division, SBO or RWA;

♦ redefinition of area of need to include specific reference to access to female practitioners; and

♦ establishment and support of female rural GP networks at the local and national levels.

Some suggested priorities for change

♦ Greater flexibility in the construction of rural incentives packages to include assistance with spouse employment, retraining or further education or business start up.

♦ Develop a package of information on salary packages and contractual arrangements for GPs working in rural and remote locations with advice on superannuation, access to the PIP, casual and permanent rates, Medical indemnity insurance, set up a company, and taxation issues.

♦ More flexible training and retraining packages for female GPs moving into or returning to rural or remote practice. Such packages need to include part-time training options and the provision of childcare.
♦ Establishment of a National Female Rural and Remote GP Network, with links to female rural and remote GPs at the Divisional and sub-Divisional levels, to provide an information, advocacy and co-ordination role on the issues of concern to female GPs in rural and remote communities.

♦ Increased representation of female GPs on the Boards of Divisions of General Practice, SBOs and RWAs to better reflect gender composition of the rural medical workforce.

CONCLUSION

The research phase of the National Female Rural GP Project is nearing completion with some clear messages already evident from the female GPs interviewed. Many of these messages are consistent with the findings of research by the RDN in NSW in 2000 and with a number of the priorities identified in the St Hilda’s Resolutions from the RACGP Inaugural Women in General Practice Conference and Workshops in October 2000.

Firstly the dominant image of a rural GP being a full-time, always available, procedurally skilled male doctor with a supporting spouse is no longer always appropriate. As such it should no longer be the underlying assumption informing government policies and programs in relation to the rural medical workforce. A cultural change has occurred in society generally as evidenced by the increasing numbers of women in the workforce and professions and the greater involvement of men in parenting and caring roles. In medicine this cultural change is evidenced by the increased numbers of female medical graduates entering GP training programs and by the increasing numbers of younger male doctors embracing more family friendly practice styles. Government policies and programs need to acknowledge these changes in the gender make-up and aspirations of the medical workforce rather than continue to support a model of medicine based entirely on the nuclear family and the heroic model of medicine.

Secondly, financial incentives do not address the disincentives associated with rural and remote practice for female GPs. Financial incentives may have been the preferred option of older rural male GPs and their organisations, but female GPs have indicated that such programs are at best short-term solutions. The “throwing money at it” solution does not address fundamental issues of importance to women GPs. This includes acceptance of female GPs preferred practice styles; recognition of the value of their contribution to rural and remote health care; and support for them in balancing their often conflicting roles of partner, parent and professional. According to many female rural GPs, the current environment often undermines, pressures or makes them feel guilty about balancing these different responsibilities.

Thirdly, incentives need to be provided that are fair to both practice principals and salaried/contract GPs. Female GPs have indicated a preference for part-time and salaried/contract positions that provide them with the flexibility to manage their multiple roles as GP, partner and parent. Incentives need to be constructed in a manner that acknowledges different styles of practice and the contribution each make to the provision of health care in rural and remote communities.
Fourthly, initiatives need to be introduced that revitalise and value small rural and remote communities, making them attractive places to live and work. Inter-sectoral and whole of government approaches need to be more than just rhetoric. Regional development and support programs need to look beyond the bottom line to incorporate the spirit of social justice and equity. Otherwise the lack of interest in rural and remote communities shown by governments will continue to be a major disincentive for female GPs and other health professionals to take up the option of rural practice.

Finally, support for female GPs in rural and remote communities is not only the responsibility of the Federal Government. All levels of government, the rural workforce agencies, State-based organisations, Divisions of General Practice, medico-political organisations and rural and remote communities and organisations need to ensure the needs of female GPs are treated as central to the medical workforce needs of rural communities. Rural communities value the contribution that female doctors make to their health care, and this contribution must be more widely recognised and supported. For general practice services in rural and remote areas to be sustainable both women and men must be recruited and retained as doctors, and the support strategies developed need to reflect this broader approach.

REFERENCES


2. ibid.


AUTHORS

Dr Helen Tolhurst is currently working as senior lecturer in rural general practice at the University of Newcastle. She has worked as a rural general practitioner for 20 years, initially in Alice Springs and for the last 15 years in Cessnock in the Hunter Valley. She was involved in setting up the Hunter Rural Division of General Practice and was the chair of HRDGP for the first 3 years of its development. She worked as senior lecturer in rural general practice at the University of Newcastle for 6 years until December 2000. She is currently working as General Practice Research Fellow at the University of Newcastle.

Her research reflects her interests in health service provision in rural areas and rural medical workforce, and has included work on the provision of emergency services in rural areas, emergency medicine training for rural GPs, women in the rural medical workforce and violence against rural GPs.
Noela Lippert is currently the Senior Project Officer for the National Female Rural GP Research Project in the Discipline of General Practice at the University of Newcastle. Noela is currently on secondment from the General Practice Branch of the Department of Health and Aged Care. She has been involved in rural health policy for more than a decade in a variety of positions both within the Commonwealth Public Service and non-government organisations, including the National Rural Health Alliance. Noela is currently doing her PhD on female general practitioners in rural communities through the School of Rural Social Research at Charles Sturt University.

Her research interests reflect a strong interest in gender issues and social justice, in relation to the delivery of rural health and medical services to rural and remote communities.