Victorian Rural Women Practitioner Survey

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INTRODUCTION

In August 2000 the Rural Workforce Agency of Victoria (RWAV) surveyed all female rural general practitioners and specialists in Victoria. The survey was carried out by Jenny Ginnane and funded by RWAV, under the supervision of Jo Wainer from Monash University. Ethics approval was granted by Monash University. The survey replicated that conducted by Kirsty McEwin from the NSW Rural Doctors’ Network and follows earlier work by Helen Tolhurst and others from Newcastle University.

Matching the NSW survey allows for interstate comparisons of data. Workforce agencies in the other states and territories have agreed to fund their own surveys, which will result in a national dataset.

The survey reflects the growing awareness among workforce planners and medical researchers of the importance of understanding how women relate to medicine. Medicine, and rural medicine in particular, used to be an almost exclusively male occupation. Now forty per cent of young doctors taking up rural general practice are female. This change has profound implications for rural medicine.1

Now that women comprise nearly half the cohort of graduating doctors, it is imperative that a much deeper understanding is developed of the way women work in their profession. The shortage of rural and remote area doctors requires the restructuring of rural practice so that it is possible for women to work in rural areas, as well as men. Women are less attracted to rural medicine as it is currently structured than men are. According to 1996 data only 17% of female general practitioners work in rural practice2 although this is changing. Rogers found that 30% of rural trainees were female3, and the National Rural General Practice Study showed that more than a third of female general practitioners aged less than 45 were in rural practice, a much higher proportion than in the older age groups4.

The alternative, which has been tried up until now, is to try to restructure women to work in male constructed practice. That has had some success and many women have taken on the challenge of working in a system which is predicated on the assumption that the doctor has a wife, and done it well and even enjoyed it. However a growing cohort of young women, and increasingly young men, are avoiding working in areas of medicine that do not allow them to live their lives as people as well as doctors. Rural medicine has been such an area.

The work builds on research carried out by universities and workforce planners, beginning in the mid 1990s. In 1996 the National Rural General Practice Study was conducted by a consortium of three universities, led by Monash University. The Study built gender analysis into the original design, and disaggregated the data by sex and
age. At the same time the Australian Medical Workforce Advisory Committee (AMWAC) conducted an analysis of workforce data, focusing on how, why and where women practised medicine\(^5\) and another reporting on the rural medical workforce\(^2\). In 1997 Helen Tolhurst and others reported on the training and support needs of female rural doctors, based on focus group and survey work with doctors in NSW and WA\(^6\). In 1998 AMWAC published a report on workforce participation which explored some of the reasons why women were better represented in some areas of medicine, and underrepresented in others, such as surgery and rural medical practice\(^7\).

These studies identified that female rural doctors have specific workforce and professional and personal needs which differ in importance and priority to their male colleagues. The studies supported the need for further research, and the importance of introducing teaching about issues for women and men into undergraduate and postgraduate medical curricula. Monash University has been funded by the Rural Undergraduate Steering Committee since 1996 to pilot and introduce teaching about gender issues and this is currently being expanded to undergraduate curriculum at Newcastle, Melbourne and WA universities. The Australian College of Rural and Remote Medicine (ACRRM) has included consideration of issues for female and male doctors in its Prospectus\(^8\), in its criteria for Fellowship, and as a core unit in its Primary Curriculum\(^9\).

In 1999 the NSW Rural Doctors Network funded a literature review by Linda Levitt which provided the foundation for the study early in 2000 which surveyed all the female rural doctors in the state, specialists and generalists. That study formed the basis for the RWAV/ Monash study reported in this paper. In 2000 the General Practice Evaluation Program funded Monash University to conduct a national survey of models of practice of female rural general practitioners and the General Practice Partnership Advisory Council Women in Medicine working party has initiated a study to underpin changes in rural medical education and rural practice to better reflect the way women work. In September 2000 the Royal Australian College of General Practitioners (RACGP) Presidential Taskforce on Women in General Practice held its first national meeting, the results of which have been published.\(^{10}\)

Australia is leading the way in systematic study of the relationship between women and rural medical practice as workforce planners and medical colleges struggle to come to grips with the implications of the different ways in which women practice medicine and combine their personal and professional lives.\(^{11}\)

**THE STUDY**

**Aim**

The purpose of the study is to contribute to building the evidence base from which workforce planners can restructure rural medical practice to attract women. This requires data on how women practice rural medicine, their relationships with family and community, and what attracts them to rural practice.

The objective is to identify issues pertaining to recruitment and retention of female General Practitioners and Specialists in rural Victoria.
It is intended that the findings of this research will be used to support the development and implementation of programs and strategies to improve the retention and recruitment of female doctors working in rural areas of Victoria, and to inform the medical colleges about the training and educational needs of female rural doctors.

This report is on the findings of the General Practitioner survey.

**Method**

In August 2000 RWAV drew on its existing database of rural doctors to post the survey designed by NSW Rural Doctors Network to all female rural doctors in Victoria. The survey was accompanied by a letter from RWAV inviting the women to respond.

The survey sought basic demographic information, and responses to questions that had been identified in previous research as being important to women. These included responsibility for children, rural exposure prior to becoming a rural doctor, the number of hours worked in clinical practice and whether this reflected the doctor’s preferred workload, involvement in hospital-based and after hours medical services, issues of importance in rural practice, and intentions to leave or change their current practice. A separate survey was sent to all female specialists in rural or regional practice. This survey included all relevant questions from the general practice survey, and several questions were modified to reflect specialist practice.

Questionnaires were sent to 271 general practitioners. Non-respondents were sent a reminder letter and a second copy of the survey four weeks after the first survey was sent out. A total of 153 replies were received, six were blank, three were from doctors who were not general practitioners, and four were not rural. This left 140 useable replies from eligible general practitioners, a response rate of 52%. There were eighteen responses from specialists, which was 58% of the sample. The low response rate contrasts with the rate in NSW, which was greater than 70%. The only identifiable difference in procedure between the two states was that the mail out in NSW was done by the Divisions and there was a six week gap between the original and follow-up questionnaire, and in Victoria the mail out was done by RWAV and there was a four week gap before the follow-up questionnaire was posted.

Data was entered in an Access database as questionnaires were returned. When data entry was complete it was checked for validity by visual inspection and examination of frequency tables to ensure that no illogical data had been entered. Numerical data were then exported to Statistical Package for the Social Sciences (SPSS), and alpha fields exported to Microsoft Excel. Eight questions allowed for qualitative responses, and this data has been analysed using Nvivo qualitative analysis software.

**RESULTS OF GENERAL PRACTICE SURVEY**

Drawing on previous work, the survey concentrated on four themes.

- Demographic data including rural exposure and university training.
- Dimensions of clinical practice and the impact of family responsibilities.
Intentions to remain in rural practice and identified issues which may underpin these intentions, including areas of possible continuing medical education.

Major issues and changes necessary to attract and keep women in rural medicine. The survey results reflect both quantitative and qualitative data.

Demographic data and workload

Location

Rurality of practice is described by the Rural, Remote and Metropolitan Area classification, or RRMA. Substantial problems have been identified with the way individual locations are classified within this system, however it is useful for comparative purposes.

This distribution is similar to that found in NSW, where between 16% of the rural GP workforce in NSW are female and 10% of rural GPs are women. The Victorian women are more likely to practice in Other Rural, and less likely to be in Small Rural towns.

Rural communities and environments are diverse. The following chart demonstrates that the presence of women in the medical workforce, and their interest in responding to the survey, varied substantially from Division to Division.
Ninety-four per cent of the respondents were members of their local Division. This is much higher than their membership of the relevant learned medical colleges. More than a third of the women were not members of any college. One third were members of the RACGP alone, another 14% were members of RACGP and ACRRM, and 9% were members of ACRRM alone. Anecdotal evidence suggests that many female doctors struggle to meet membership fees because their practice style means they have lower incomes than their male colleagues.

Marital status
A Professor of General Practice has been heard to advise her students who are interested in rural practice to find themselves a partner before they go to the country, it can get lonely out there, especially for young single women. Some rural communities are at a bit of a loss to know what to do with single professional women, although they take to the young men more readily. It seems that the great majority of women have taken this professorial advice. Very few of the women defined themselves as single, although 12% were not in a current partnership. Eighty-eight per cent identified as either married, in a defacto or same sex relationship. Most of the women (7%) who were not in a partnership had been at some time and were now either widowed or divorced.

The National Rural General Practice Study figure for Victoria, based on data collected in early 1997, found 12 per cent of women were not in a marriage-like relationship. Female general practitioners are more likely to be in a relationship than specialists. The Australian Medical Workforce Advisory Committee study on participation in the medical workforce interviewed 296 doctors from all areas of medicine. They found that 23% of the women were not in a relationship, and half of the women older than 39
years not in partnerships were specialists. Data from 1991 reported in the AMWAC study on female participation in the medical workforce\(^5\) found that nationally 22% of rural female general practitioners, and 29% of female rural specialists were not married. This data may not be directly comparable to the NRGPS and the current study, which included women in marriage-like relationships as well as women who were actually married.

AMWAC found that nearly one third of female general practitioners had medical partners\(^7\). The current study found an even higher number of rural female doctors had medical partners.

**Figure 3 Occupation of partners of Victorian rural female general practitioners**

Women have identified some of the main advantages of having a medical partner in a rural setting. These include the ready availability of work for their partner, the opportunity to back each other up, debrief, share the stresses and pleasures of the job, and manage their workloads with more flexibility. Some of the disadvantages include the difficulty of taking time off together, and increased disruption to family life because of the doubled “on call” time for the family\(^13\).

**Age**

The results of the survey confirmed the trend to higher proportions of female rural doctors present in the younger age groups identified in the studies quoted previously. Forty-two per cent of the women were aged between 30–39 years, another 42% between 40–49 years, and only 16% were older than 49. This differs from the pattern evident in studies of the whole rural medical workforce, which demonstrates an ageing of the workforce\(^4\).
This study shows that the Victorian women have a similar age distribution as the women who comprised 23% of the National Rural General Practice Study. Sixteen per cent of both samples are aged less than thirty-five, and 24% are aged between 35–39 years. Twenty-seven per cent of the doctors in this study are aged 40–44, 16% aged 45–49, 10% aged 50–54, and 3% aged 55–59, so that the age distribution peaks during the most demanding child-rearing years. This contrasts with the male doctors in the National Rural General Practice Study, who are substantially less likely to be in the younger age groups. As the older male doctors retire they are increasingly likely to be replaced by younger women, with demonstrably different values and work patterns.

Effect of marriage and parenting on clinical and other professional working hours

Women have consistently identified the work they do as parents, mostly with limited assistance from their partners if they have one, as a major influence on the way they practice medicine, and their choice of area of medicine in which to practice. Eighty-four per cent of the women had children. The National Rural General Practice Study identified 70% of Victorian rural doctors (male and female) as having children at home. The women had a total of 294 children at home, 55 of whom were aged 18 or more. When asked who carried the main responsibility for caring for the children, 65% of the women said they did. One third of the women have found creative ways to share the responsibility. More than half the women not in a relationship had children (10 out of 16), and the responsibility to care for them (7 out of 10). Eighty-nine per cent of women in a relationship had children, and 59% had the main responsibility for their care. Having children led to an average reduction in clinical working hours from 36 hours per week for women without children, to 26 hours per week for women with children. The effect was even more marked for non-clinical work. Women without children worked an average 21 hours per week in non-clinical work (although the high standard deviation suggests an outlier in the data) and the women with children worked...
an average of 9 hours a week in non-clinical work. Women who were in a partnership, whether or not they had children, also reduced their clinical hours (26 hours) compared with women who were not in partnerships (34 hours), but there was no difference between the two groups for non-clinical working hours.

The women who worked the least clinical hours were those with responsibility for children. They worked an average 23 clinical hours and 8 non-clinical hours per week, compared with women who did not have primary responsibility for children, who worked an average of 31 clinical and 10 non-clinical hours.

In summary, having children and being in a marriage-like relationship has a similar but independent impact on clinical workload, but the greatest impact is on women who have responsibility for their children, whether or not they are in a relationship.

Figure 5  Number of children of Victorian female rural doctors

![Bar chart showing the number of children of Victorian female rural doctors.](chart.png)

Women are challenging the notion of what is a reasonable workload, and particularly the AIHW definition of part-time work as being 40 hours per week or less. When asked to self-describe their workload 63% said they worked part-time and 83% said this was for family reasons. Despite the high percentage of part-time work, 36% wanted to work fewer hours, and only 4% wanted to work more. One of the attractions of general practice is the ability to work flexible hours during years of family responsibility, and this is one of the attractions to women, who strongly value their role as parent and caregiver.

Reasons for choosing rural practice

Medical schools are encouraged by the Commonwealth Department of Health and Aged Care to increase the number of students from rural areas into medicine, based on research which demonstrates that the two main predictors of a doctor practising in a rural environment are having been brought up in the country, and having positive
experiences of rural medicine while an undergraduate. This research has been done on a predominantly male data set and it is heartening to see it confirmed by the current study of female doctors. Nearly 40% of the women said they were raised in a rural environment.

In 1992 Strasser found the main attractors to rural practice included the variety of rural practice and country lifestyle. This was also reported by Gill. AMWAC reported that the pleasures of the rural lifestyle and scope of practice were important considerations in the decision of female doctors to remain in rural practice.

This study confirms that lifestyle and scope of practice are major attractors to rural practice for women. Sixty-two per cent quoted lifestyle as a reason for choosing rural practice.

I enjoy the rural lifestyle and the outdoor life. I/we wanted to bring up our children in the country perceiving it as safe and supportive — which it has been.

Wanted to move and settle in the country for family and personal reasons — beauty, space, fresh air, recreational pursuits, love of bush and sea, more holistic lifestyle. The work was to be a means to an end but I do love the continuity of care in a family practice.

Eighteen per cent of the women nominated the extended generalist nature of rural general practice as a major reason for wanting to be a rural doctor. They liked the challenge of providing extended levels of care in an area of medical need.

Work opportunities of greater independence and autonomy with opportunity to use a wide range of procedural skills; greater connection with and immersion into the community I serve.

I enjoyed the challenge and diversity of rural practice.

Increased opportunities to use skills: anaesthetics, accident and emergency and inpatient management.

I had always wanted to work as a GP with hospital access.

The great majority of the women surveyed are planning to stay in rural practice. Sixty-eight per cent do not intend to leave their current practice in the next five years and 19% are undecided, but 18% intend to change the nature of their practice. This may reflect the high percentage (50%) for whom their current practice is their first experience of rural medicine.

**CONCLUSION**

Workforce planners, medical colleges and universities are beginning to recognise the complexity and importance of the issues raised by the change in the sex ratio of the graduating medical workforce. Women have a cyclical relationship with their profession, and require structures and systems that recognise and value the way they experience their lives as women, and as doctors. Rural medicine has been the part of the profession which has recognised the significance of this and is taking the lead in gathering the evidence on which to base professional training and structures in order to attract and retain women into rural medicine.
The findings from this study

♦ support a continued emphasis on recruiting rural students into medicine;
♦ the key role of Divisions in adapting rural practice to reflect the way women work;
♦ the need for the learned medical colleges to work harder to attract women as members;
♦ further exploration of the advantages and disadvantages of two-doctor marriage-like relationships in rural practice;
♦ further understanding of the variety of family circumstances of female doctors;
♦ systematic exploration of the experience of single doctors;
♦ embedding fractional clinical and other professional loads into the design of rural general practice; and
♦ develop systems to ensure that women who are attracted to this aspect of rural medicine have the opportunity to provide extended general practice services.

This study is particularly important because it complements that done by NSW and provides the beginning of a national data set, and because it was developed on the basis of women’s experience rather than using men as the point of comparison.

REFERENCES


6. Tolhurst H, Bell P, Baker L, Talbot J, Cleasby L (1997) Educational and Support Needs of Female Rural General Practitioners School of Nursing and Health Administration, Charles Sturt University, Bathurst NSW.


**AUTHORS**

Jo Wainer is a medical sociologist working in rural health. She is a senior lecturer at Monash University School of Rural Health with an international reputation in gender analysis and medicine.

She was an advisor to the secretary general of the UN Fourth World Conference on Women in New York, and attended that conference in Beijing (1995) as a member of the secretary general’s staff, as well as the PrepCom in New York. The following year Jo was the NGO representative on the Australian delegation to the UN Commission on the Status of Women in New York.

Jo was a contributing editor for the World Organisation of Family Doctors (WONCA) policy on Rural Health and Rural Practice (1999). In 2001 she will co-facilitate a workshop on gender issues and a session on women in leadership at the 16th World Congress of Family Doctors, WONCA 2001, Durban. She has presented papers at several WONCA conferences; in 2000 she was an invited keynote speaker at the 4th WONCA World Rural Health Conference in Calgary, and her presentation was videotaped for later use in distance education programs for Canadian rural doctors.

Jo co-authored the Australian College of Rural and Remote Medicine (ACRRM) policy on Women in Rural Practice (1997). She has developed curriculum on gender issues for rural doctors for postgraduate training through ACRRM and for undergraduate medical students at Monash University.

She is a member of the Women in Surgery Committee of the Royal Australasian College of Surgeons, the Women in Rural Practice Committee of the Australian College of Rural and Remote Medicine, and the Women in Medical Colleges group.

Jo chaired the Board of Management of Women’s Health Victoria, the State-wide government funded women’s health service, from 1994 to 1998 and was a member of the National Health and Medical Research Council’s Expert Panel on Termination of Pregnancy Services which reported in 1997.