Place matters! Rural as an 'enabling culture' for female GPs

Imogen Schwarz, Water in Drylands Collaborative Research Program, University of Ballarat, John McDonald, Centre for Health Research and Practice, University of Ballarat

Introduction

This paper presents empirical research that is set within the conservative and male-centeredness of the medical profession1–5 and rural communities.6–8 It explores how female rural GPs can rework these spaces to achieve personal and professional satisfaction. This study was part of doctoral research funded by the Australia Research Council (Project # C00107622) to improve recruitment and retention of GPs in rural Australia.2 The key research question that informs this paper is: What new or alternative discourses have been created by women rural GPs and how does the rural context provide the milieu for women to rework these spaces?

Male general practitioners (GPs) still far outnumber female GPs: as at 2004–05, there were 15,590 males compared to 9,079 females. Male GPs also predominate in non-metropolitan areas. The Department of Health and Ageing9 further reports that a total of 2,235 female GPs are practising in rural and remote areas compared to 4,712 male GPs. However, over a ten-year period from 1995–96, the proportion of rural GPs who are female has steadily risen: there has been a 56.5% increase in female GP’s practising in rural and remote areas compared to an 18.1% increase in male GPs. A higher proportion (35%) of female GPs now work in very remote areas than in any other area—including major cities (p. 325).10

To some extent, this reflects the shift in the gender balance of medical graduates. 2001–02 was a signal year: for the first time ever, the total number of female GPs across Australia aged under 35 years (1,669) outnumbered male GPs aged under 35 years (1,396). A recent survey11 of GPs in Victoria confirms these trends. Female GPs make up nearly one-third of all rural GPs, and comprise almost half of all rural GPs aged under 40.

Recent research shows that work patterns differ considerably between the genders. Male rural GPs reported working much longer hours than female GPs (49.8 hours compared to 34.4 hours), though female GPs’ hours pick up again once they reach their early to mid-forties.11 This reflects the fact that female GPs are very likely to have primary care-giving responsibility for their children. Female rural GPs identify that the four most important issues are family rather than professionally-related: child care, a place for their partner, managing after-hours commitments and balancing work and family all rated above professional and practice issues.12 Various factors operate to influence a GP’s decision to remain in rural practice. The salient priorities for female GPs are different from male GPs. GPs generally value good on-call arrangements and professional support. However, younger, female GPs with children or working part-time also place a high priority on the local availability of community services and geographic attractions.13

However, there is some early qualitative evidence14 emerging from both male and female medical students that we may be witnessing a generational change in trying to balance work and family commitments—or at least an intention not to become enslaved to medical practice. Significantly, medical students indicated that they would seek out locations, disciplines and organisational arrangements where it is possible to strike a work and family balance.

The undersupply and misdistribution of GPs remains a critical problem.10 A range of strategies have been introduced over the last 10 years to actively manage the distribution of GPs across Australia. These include bonded medical places, recruiting overseas trained doctors, funding regional medical schools and University Departments of Rural Health, and the provision of incentive payments.15 These

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1 The authors acknowledge the support provided by industry partners: Ballarat District Division of General Practice; and Beaufort and Skipton Health Services; and wish to thank the women who openly and enthusiastically shared their time and work/life experiences for this doctoral research.
rural recruitment and retention strategies still largely ignore the reality of the changing gender profile of GPs and fail to specifically address the needs of female GPs.

The traditional model of rural general practice (abbreviated in this paper as the ‘super-doc’ model) has for a long time been male centred. This model based on a full-time procedural skilled, male doctor, with a supporting spouse was “considered largely irrelevant to the practice reality of the majority of female GPs interviewed” in a national female GP study. The so-called “feminisation of the medical workforce” is typically used in a very restricted sense to refer to the increasing proportion of female to male GPs. Because medicine remains an essentially patriarchal institution, the notion of “feminisation” has not yet progressed to refer to the deliberate structuring of workforce policies to cater for the needs of female rural GPs. Government policy and workforce agencies must come to appreciate 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”.

Method

A qualitative design was employed, using in-depth tape-recorded individual interviews with a purposively selected group of thirteen female GPs from rural South-East Australia to identify examples of successful practice. Table 1 presents demographics and the work profiles of the interviewed women. Findings were uncovered through thematic analysis of transcribed interviews. The enabling culture is the final stage of a four stage pathway of change identified in the study. Through this pathway women actively negotiate/reject the super-doc work model and values, and (re)work the definitions of what it is to be a rural GP towards a women-defined model of rural general practice at stage four. This model builds on existing knowledge by validating women’s experience and most importantly, viewing women as active negotiators and shapers of their work/lives. The focus of this paper is on the final stage of this model. Pseudonyms are used in place of real names to maintain anonymity of interviewed women.

Findings

Contrary to the prevailing ideas about the patriarchy of medicine and the masculinity of rural communities, the study identified that a rural environment can provide space for women to (re)create their own way to practice. Key characteristics of this enabling culture for women GPs, pertaining to the rural context, are detailed below.

Rural as enabling women’s practice style

Broad scope of practice

The data revealed that a main attraction to working in rural environments is the broad scope and generalist nature of rural practice. Other studies of female rural GPs in Australia support this finding. Hospital access including emergency medicine is appealing dimension, unique to rural as compared to metropolitan-based practice. Women enjoyed the opportunity to apply a variety of skills, and treat a myriad of different patients and patient problems, as well as provide extended care to patients in and out of the local hospital system. The authenticity of general practice in a rural location, and the closeness at which these women were able to treat patients, provided “good training,” and “interesting” medicine.

Whole-person perspective

Another critical feature of rural practice which fits with a women-defined practice discourse is the notion of “continuity of care” and “cradle to grave” medicine. In contrast to urban practice, women GPs identified that rural practices do not act as “referral centres,” but manage the care of their patients within the clinical, hospital, and sometimes the home setting.
### Table 1  Summary of demographic and working profiles of interviewed women rural GPs

<table>
<thead>
<tr>
<th>Demographic and working profile</th>
<th>Case study (no.)</th>
<th>Case study (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women interviewed</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>RRMA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural 4 (Small rural centre with population 10,000–24,999)</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Rural 5 (Other rural areas with population &lt; 10,000)</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Spouse Occupation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>2 (ex-spouses)</td>
<td>15</td>
</tr>
<tr>
<td>Farmer</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>House husband</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other (includes business owner)</td>
<td>9</td>
<td>70</td>
</tr>
<tr>
<td>With children</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Single with children</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Rural background:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Partner</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Both</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Practice Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Group of 2</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Group of 3 or more</td>
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<tr>
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<td>45</td>
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<tr>
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<td>23</td>
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<tr>
<td>Salaried</td>
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<td>8</td>
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<td>Contract</td>
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<td>0</td>
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<tr>
<td>Associate</td>
<td>2</td>
<td>15</td>
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<tr>
<td>Locum</td>
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<td>0</td>
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<tr>
<td>Registrar</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Hours worked:</td>
<td></td>
<td></td>
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<tr>
<td>Full time</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Part-time</td>
<td>2</td>
<td>15</td>
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<tr>
<td>On call</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Performs procedures</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Planning to stay in this location</td>
<td>10</td>
<td>77</td>
</tr>
</tbody>
</table>

Source: Schwarz, 2005" p. 281. Table adapted from Tolhurst and Lippert.¹

The interrelatedness of rural communities enables female rural GPs to know the patient in the context of the whole, as Wainer¹⁷ notes, “within their family, work and community setting” (p. 29). Women frequently used the term “rubber stamp GPs,” or “referral GPs” to differentiate between the more detached, less continual nature of doctor-patient relationships in city settings as compared with more bonding relationships formed by being a GP in a rural community.

**The sense that you’re it**

In rural practice, women recognised their identity as “a valued member of the community” (Fiona) and the difference they made to patient’s lives and to rural health care.
Patient demand for female GPs and GP shortages exacerbated the “sense that you’re it.” Women saw their importance in providing for rural communities by offering a different type of care, such as emotional care or a “female option” (p. 2). This finding was consolidated by women’s personal meanings of success as a rural GP—this included being valued by their patients. In particular, success was based on more relational aspects of their professional role, such as feeling needed by and developing rapport with patients, rather than on high patient turnover and high income.

Underlying the women’s stories of serving rural communities were altruistic values. The resilience of women was very evident in the interviews. Women revealed a commitment to fulfil the role as doctor for the rural community, yet at the same time report needing to be a ‘good’ mother and partner. Other altruistic tendencies were expressed in some women’s sense of ‘calling’ to their rural town, and sense of vocation to serve in “places that are needy” (Katrina).

Create own space

The findings suggested some association between the opportunity for women to create their own practice structures within the rural context and women’s professional satisfaction. A number of factors increase women’s ability to create their own space within the rural context including capacity for decision-making (predominately in the role of principle/partner/solo practitioner); the shortages of rural doctors, therefore, more tolerance for different ways of working to ensure the practice retains its workers; a high demand for women doctors; and the autonomy within rural general practice.

Jane (solo practitioner): Being on your own is lovely because you can do your own thing, and have your own atmosphere.

A number of women were creating their own space by branching out into new areas of medicine including nutritional medicine, hypnosis and acupuncture that fulfils their need to “inject some new interest” and “new challenges” into their practice, as well as being personally “rewarding”. Rural general practice enabled women to have this variety of practice “without having to jump ship” (i.e. change professions) and the rural context meant that there was less availability of these therapies, and thus more of a need for complementary medicines in rural communities.

Rural as enabling women’s health care philosophy

Slow medicine is a term that describes women rural GP’s practice approach and philosophy of health care. Slow medicine is markedly different from patriarchal medicine, that women rejected in stage one of the four-stage pathway. Slow medicine is more about the art of medicine including patient-centred care; ‘a conversational style’ of consultation (Janette); subjective ways of knowing; meeting the genuine needs of patients—all of which encompass the bio-psychosocial model of care. It is desirable that ‘slow medicine’ become part of the overall workplace philosophy because “your ethic and way of running your practice ... is different” (Jane)—high turnover and high income is less of a priority.

From the thirteen case studies, four women (Janette, Fiona, Di, Jill) identified that their group practice had adopted the slow medicine model as a practice philosophy. One female GP of a large group practice felt that this change was due to the males in the practice realising that “it’s not good medicine to be churning people through really quickly. [Now] most of the fellas are seeing patients every fifteen minutes as well” (Fiona). Janette also recognised that male colleagues were “more along this line of thinking than anything else”. Women of these practices reported that male doctors were increasing counselling-type workloads, which typically was viewed as the female GPs’ obligation.

Rural as enabling women’s work/life structures

An enabling culture was identified where women participants joined practices in which the presence of female practitioners had collectively influenced work values and structures. An enabling culture also developed where women personally implemented these elements. This was achieved by setting up a practice of their own (going solo); inviting colleagues with similar values to join their practice; or making amends to individual workplace settings to make it more like their own values, inside practices with less compatible traits.
Non-hierarchical/collaborative work model

Women were reconstructing practices based on women-defined values of mutual respect, trust, equality and collaboration. Three women job-shared patients (Katrina, Kirsten, Fiona) and two GPs hoped to employ a part-time female GP to share the ‘female’ patient-load. In addition, two women who initially set up practice for themselves now employed women doctors. A study\(^5\) of Australian female rural GPs identified that working with another female GP enabled them to have a greater variety of patients and better share of acute cases. Social and professional networking, in particular, occurred with other women in the practice—whether administration staff, nurses, colleagues or other allied health professionals. Existing research suggests networking between women health professionals is an important retention factor salient to the needs of female rural GPs.\(^2\)\(^2\)\(^\text{-4}\)

In addition, being a member of a rural ‘medical family’ was valued by the women GPs. Women appreciated the supportive, collaborative network encompassing the wider rural health community including specialists, neighbouring GPs, hospital staff and closer networks within their practice—administrative staff, colleagues, practice nurses and allied health practitioners.

Respect between the women GPs and other rural health professionals was a recurring theme, indicative of their personal philosophy and characteristic of rural communities that are generally close-knit, respectful and supportive of one another.\(^2\)\(^5\) The women reported positive relationships with specialists and local or neighbouring GPs that assisted women to solve patient problems locally—preserving the scope of practice and extended nature of care was important for the women. In addition, the remarks of the women interviewed supported research by Blue and Fitzgerald\(^2\)\(^6\) on nurse-doctor relations in four Australian rural towns. Their study highlighted that relationships are “co-dependent ones in which neither rural nurse nor GP could operate successfully without the other” (p. 321).

(Re)constructing the rural practice with these work values, and in particular having “practice approaches similar to your own”\(^1\)\(^6\) philosophy is likely to assist in the retention of female GPs to rural areas. The support of a rural medical family is also an important sustainability factor.

Supportive work model: Flexibility and balance

An enabling culture for women included flexibility as part of the practice philosophy that recognised a need for a balanced approach to life. In this study, women with young children at the time when they joined the practice had successfully negotiated their preferred work hours. Wainer et al.\(^1\)\(^6\) noted that having children is seen as a legitimate reason to pursue flexible work conditions. Female GP studies emphasise that heavy after-hours and on-call workloads are significant stressors for women,\(^2\)\(^4\),\(^2\)\(^7\),\(^2\)\(^8\) particularly with family responsibilities.\(^1\)\(^2\) Wainer\(^1\)\(^2\) suggests that when women doctors are “recognised as women as well as doctors” (p. 52) flexibility will become the basis for future workforce planning.

This research identified sustainable strategies women implemented to make workloads “more manageable”. Strategies included job-sharing on-call or having a second doctor on-call; participating in rosters less often by collaborating with neighbouring practices or towns; having an adequate nurse triage or experienced nurses at emergency departments so GPs are called only in genuine emergencies rather than for every case; having a ‘predictable roster’ to organise yearly calendar (including professional development, weekends and time-off with family); and ensuring doctors not on-call have time “completely off” (Kirsten).

Women have also identified, like Worley,\(^2\)\(^9\) the need to increase the number of doctors per town in order to reduce heavy workloads. This supportive work strategy concurred with the findings of Tolhurst and Lippert\(^6\) who found larger group practices more attractive to women to enable women to divorce selves from the discourse of overwork.

Women identified various ways of reducing hours and workloads in both the domestic and the practice spheres to achieve a sense of balance. Establishing priorities and setting boundaries on personal and professional life were important for women in balancing. In the practice, for example, women set limits on patient bookings; employed additional staff; and kept work issues separate from home life. Setting these limits did not mean women lacked commitment, it was quite the opposite. As a rural GP, the sense of commitment was ever-present, the difference was that women were moving beyond the ethos
of overwork and creating more sustainable structures. In broader terms, if the culture underpinning rural general practice would value self-preservation rather than overwork this would perhaps assist sustainability factors.

Balancing was seen as important in their lives to sustain positive feelings and to “have joy in life”; to prevent burnout and reduce exhaustion; and in turn be able to sustain a role as a doctor for their rural community. This included giving self permission to “have me-time” (Katrina); to spend time with family/friends; and to pursue non-medical interests. The emotional support of a “good marriage” and a “confidant” were also “enormously powerful” ways of reducing a sense of isolation. In addition connections with non-medical people and activities are “crucial sources of stability and balance” (p. 1257).

Rural as “making the community your own”

Making the community your own, was a successful rural GP retention strategy identified by Wainer et al. The term is analogous with women’s sense of belonging in their community and their contentment with rural practice. Settling into a rural town is experienced differently by women’s connections to place (including rural/urban background, people, lifestyle and space), and the extent to which they make the community their own. The major themes are discussed below.

Near the familiar

The first theme centres on place connections for women GPs in terms of being near the familiar and which influences decisions about work locations. The main features were:

- living close to family or re-settling family members into their rural communities;
- choosing towns where they had positive rural placements on both a social and professional level; and,
- choosing towns with established referral networks and being familiar with the hospital system in a particular state.

The factors of being ‘near the familiar’ suggest women are more likely to be content with their rural place and enable them to make it their own.

The ‘values of country life’

Women identified ‘values of country life’ that were actively pursued by some and appreciated by all those interviewed. Positive features of rural living entailed a sense of belonging by living in a community that is “caring and connected” (Kirsten) and is distant from the “rush, noise and pressures” (Irene) of city life. The open space and beauty of a rural environment, the close geographic proximity of work, home and services to each other, and the safe and supportive environment of country life were other positive features that women mentioned. Similar findings are reported in other female rural GP studies.

Attuned to the rhythms of local community life

Most women had a good understanding of people in their community including how they lived and things of importance to them. Green and others note that understanding the nature of each community, including its local values, are essential for health professionals moving to rural towns in order for retention.

Katrina: To be a rural GP is … to know what’s going on in people’s lives … like [during harvest] it was really important to get people back to work as quickly as possible.

“Getting involved”

Through their initial experiences of settling into a rural town, women highlighted the significance of the community’s involvement in retention of GPs. The “community’s welcome and supportive measures” were valued by GPs and are important catalysts for community attachment. Poor
relationships with key local figures\textsuperscript{33,34} and the lack of integration into rural community life\textsuperscript{32} are reasons for GPs leaving rural practice. Therefore, ways to enhance the professional and personal supports within the community are important for retention of GPs. This includes initiatives that assist GPs to become familiar with local communities\textsuperscript{23} such as orientation programs, rural placements, and locum work.

Some women actively made rural places their own by “getting involved.” “Getting involved” provided women ways to be part of the community which reduces isolation, increases connections to that place and influences their length of stay within the community. Community reactions and personal attitudes amongst the women varied to the notion of “getting involved”. The process required development of mutual trust—that the doctor accepts the community and the community accept the doctor. Due to the overlapping nature of social and professional ties in a rural context, sometimes women struggled with these blurred boundaries.

However those women, who actively pursued involvement in their rural communities, were able to develop social ties beyond their professional practice. Through assuming various identities (ie. mother, wife, partner of a local lad, family member, and professional) women can make multiple connections with their town that shifts their positioning from the town doctor to “just a person” (Sue). Women’s actions therefore, reflect a new interpretation of being a rural GP, an occupational as opposed to vocational viewpoint\textsuperscript{4,23} (ie. one that has a more blended approach to work and life). The ability of ‘getting involved’ with the community to a point where the doctor “loses [their] tags” (Lena) was the point where women really connected with their community.

Conclusion

Rural workforce recruitment and retention policies largely ignore the socio-cultural context and how place shapes the social relationships and meanings of rural practice. This study found that female rural GPs can derive great personal and professional satisfaction from rural practice. Moreover, the rural setting itself offers an enabling culture for female GPs.

Recommendation

That work be undertaken with key stakeholders to promote adoption and integration of those enabling factors pursued by female GPs in this study, into rural recruitment and retention initiatives, so women GPs may begin to view rural practice as sustainable.

References

1. Pringle R. Sex and medicine: Gender, power and authority in the medical profession. Cambridge; 1998.


**Presenter**

**Imogen Schwarz** is a research fellow for the Water in Drylands Collaborative Research Program (WIDCORP) at the University of Ballarat, Horsham campus. Imogen’s current research focus is examination of the socio-economic impacts of water infrastructure change on rural dryland communities. Other research interests are in rural sociology, rural health and gender. In 2005, Imogen completed a PhD study on recruitment and retention of female rural general practitioners. This qualitative study involved in-depth interviews with women activists and female rural GPs to examine the ways in which women are altering meanings and structures of rural general practice at institutional and practitioner levels.