NSW Rural Doctors Network Discussion Paper

Wanted: New Rural Workforce Strategies for Female Doctors
Findings from a Survey of Women in Rural Medicine

Incorporating: Women in Medicine Literature Review
by Dr Linda Levitt & Kirsty McEwin

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1. Executive Summary

With the increasing representation of females in the medical workforce and with an ongoing rural medical workforce shortage it is critical to have recruitment and retention strategies in place in NSW to suit the diversity of medical practitioners, male and female. During 2000 the NSW Rural Doctors Network (RDN) surveyed female and male general practitioners and female specialists working and residing in rural and remote NSW to determine if RDN's strategies to attract and support rural and remote doctors are likely to be as effective for female doctors as for male doctors. The findings of RDN's research suggest that additional strategies are needed to attract and retain females to rural practice.

The findings from the surveys confirm that RDN's current strategies are likely to be effective for the majority of male medical practitioners, and further, that the changes that the male general practitioners would make to improve recruitment and retention rates to rural and remote practice are closely aligned with strategies already in place in NSW. The females surveyed raised very different issues from those raised by the males. Males tended not to mention family responsibilities whereas the females were very concerned about difficulties related to balancing professional and family responsibilities. The findings suggest that RDN should introduce additional "family friendly" rural medical workforce initiatives. Research elsewhere suggests that there are increasing numbers of younger males who are also wanting to adopt more "family friendly" modes of practice. A number of recommendations are made in response to the findings from the surveys.

Recommendations are included that aim to address the difficulties associated with balancing family and professional responsibilities. This is in response to the four major themes that emerge from the female medical practitioner responses:

- The role conflict that the women experience - balancing work and family life – Female rural and remote medical practitioners have the major responsibility for the care of the children. Male general practitioners do not, as a rule, have the main responsibility for raising children.
- The need for flexible practice and training opportunities –Female medical practitioners want flexible working and training arrangements - part time and job sharing opportunities, salaried as well as private practice arrangements, on call and after hours arrangements which do not compete with them as the primary family carers.
- The desire for support networks to overcome social and professional isolation –and linked to this is continuing medical education (CME) to be responsive to the issues that affect them as female practitioners.
- Spouse Issues – Women tend to follow their spouses/partners. The survey found 38% of the female general practitioners are in the rural or remote workforce because of their husbands/partners. This has implications for females in rural practice who may not have trained for rural practice.

Another important finding is that a high percentage of male and female medical practitioners surveyed would prefer to work fewer hours, but are prevented from doing so primarily by the rural medical workforce shortage and financial considerations. Almost half of all medical practitioners intend to, or may leave, their current practices within five years. This confirms that

the rural medical workforce is very mobile. Recommendations are made that aim to address these issues as well.

2. Recommendations

Recommendation 1: (A) RDN actively promotes policies that encourage flexible working arrangements that take into account family responsibilities; and **(B)** RDN identifies part time, job share positions and salaried positions in rural and remote areas including part time Visiting Medical Officer (VMO) appointments at Area Health Services; and also **(C)** local councils, health services, communities and rural Divisions of General Practice promote these positions.

Recommendation 2: RDN and the Rural Medical Training Forum (RMTF)[1] actively promote policies that encourage flexible training arrangements that take into account family responsibilities, including the development of formal links to this end with the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practice (RACGP) and the new regional consortia for general practice training.

Recommendation 3: (A) RDN actively promotes policies that encourage further flexible training and working arrangements that take into account family responsibilities for junior medical officers at rural base hospitals; and **(B)** RDN identifies part time, job share positions and salaried positions available for junior medical officers and also that Area Health Services and NSW Health promote these positions.

Recommendation 4: RDN continues to provide presentations *at each* Rural Refresher conference on the topics requested by the female medical practitioners with considerations made for family commitments. Topics offered should include: dealing with discrimination; dealing with role conflicts; dealing with unsafe situations; management and negotiation skills; dealing with low self esteem and skills to assist in returning to practice after time out; dealing with depression, stress and discrimination.

Recommendation 5: A target is set for 50% of the presenters at RDN's Rural Refresher conferences to be female. This sends a positive message to younger female medical practitioners and female medical students attending the conferences.

Recommendation 6: As part of RDN's policy of holding annual "topic specific" conferences, it is recommended that RDN organises one additional conference per year on leadership skills for female rural practitioners. Women general practitioners remain under represented on boards and committees and this would be a positive step towards addressing the imbalance. It also sends a positive message to younger female medical practitioners and female medical students.

Recommendation 7: RDN and the Rural Medical Support Forum[2] (RMSF) actively pursue the recruitment of additional female GP locums and subsequently advertise their availability to female GPs.

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[1] The Rural Medical Training Forum is the coordinating forum in NSW for all matters relating to rural medial education and training and includes representation from all key stakeholder organisations.

[2] The Rural Medical Support Forum is the major advisory body that provides RDN with strategic advice and information on issues relating to improving recruitment, retention and sustainability of the rural and remote medical workforce. The Forum comprises representatives of local government, community, rural GPs, Divisions of GP, federal and state health departments and is chaired by RDN.

Recommendation 8: (A) RDN and the RMSF broaden the scope of the retraining grants offered through the Rural and Remote General Practice Program[3] to include "re entry to the medical workforce" grants and further, that the criteria for all retraining grants be made more flexible to encourage more women to take advantage of the grants. **(B)** It is also recommended that childcare costs (as required) be covered by the retraining grants.

Recommendation 9: RDN (through its RRGPP Sustainable Practice grants), funds Division(s) of General Practice, to establish two pilot female support groups – one being via face to face meetings and the other being via teleconferences. Successful models already exist within at least two Divisions of General Practice. RDN should also support additional Divisions if they express interest in establishing support groups.

Recommendation 10: RDN establishes a pilot Statewide email forum for women doctors. The Forum could include a monthly newsletter incorporating news of activities of women's support groups as well as information likely to be of interest to female practitioners. Those doctors unable to easily access email messages could be sent hard copies of the newsletters.

Recommendation 11: RDN, working with rural Divisions of General Practice, actively encourages all types of childcare (ie routine, after hours, emergency etc) being available for female doctors. This includes working with the Country Women's Association, local government, local health services and other stakeholders to provide local childcare.

Recommendation 12: RDN examines *all* its current recruitment and retention strategies to ensure that they actively target women as well as men. In particular, initiatives have recently been introduced as a consequence of the Federal and NSW Health Ministers' agreement on overseas trained doctors (OTDs). RDN manages most of these initiatives in NSW and must ensure that the initiatives address the issues of female OTDs.

Recommendation 13: (A) RDN researches (or participates in collaborative research) the attitudes of female and male medical undergraduates towards rural practice (this will inform future recruitment strategies); **(B)** RDN works with the three NSW Medical Schools and the RMTF to offer female medical students the opportunity to be placed with female rural practitioners on rural placements; and **(C)** RDN continues to support Rural Health Clubs, in particular their gender initiatives.

Recommendation 14: RDN researches (or participates in collaborative research) the attitudes of female and male junior medical officers working in rural base hospitals to determine how similar or different the attitudes of young male and female medical practitioners are in NSW to rural practice.

Recommendation 15: RDN undertakes a prospective study to monitor and report on career decisions made by medical undergraduates holding RDN cadetships, Bush Bursaries and the

[3] The Rural and Remote General Practice Program is funded by the Commonwealth Department of Health and Aged Care and administered in NSW by RDN.

Country Women's Association (CWA) scholarships and the factors influencing them in their workforce decisions.

Recommendation 16: RDN, in consultation with rural Divisions of General Practice, prepares formal guidelines, which include appropriate checklists, for communities and health services to encourage succession planning for medical services. This could be prepared under the auspices of the RMSF and its distribution and promulgation funded through the Rural and Remote General Practice Program.

Recommendation 17: RDN, in consultation with the local Divisions of General Practice and other stakeholders, develops, implements and provides ongoing support for two different models of sustainable rural and remote general practice funded through the RRGPP Sustainable Practice grants-
(A) The first model would be in a small remote solo practice town and would be guided by current RDN/ RMSF activities related to sustainable models of practice. Guidelines currently exist to assist the process and the Rural Medical Support Forum actively supports such endeavors.
(B) The second model of sustainable practice is more unusual and would be based on identifying two or three *female* medical practitioners and developing a practice around their needs eg for flexible practice arrangements, retraining, childcare and so on. This model would be more likely to be located in a larger community but would involve all stakeholders and most importantly the rural Division of General Practice.

Recommendation 18: The Rural Medical Family Network (RMFN)[4] considers innovative ways to promote employment opportunities for spouses. This could, for example, include arranging low interest loans for spouses wanting to establish business enterprises.

[4] The Rural Medical Family Network is funded by the Commonwealth Department of Health and Aged Care and supports families and spouses of rural and remote GPs. It is administered by RDN.

3. **Introduction**

3.1 NSW Rural Doctors Network

As in other countries, initiatives have been introduced in Australia by state and federal governments to address the difficulties in recruiting and retaining medical practitioners to rural and remote areas. One early initiative was the establishment of the Rural Doctors Resource Network in 1988, which became the NSW Rural Doctors Network (RDN) in 1998. RDN aims to support and increase a continuing and high quality rural medical workforce in NSW.

RDN's recruitment and retention strategies are focused on short term and long term initiatives. The initiatives are designed to address both current rural and remote medical workforce needs and to attract potential "future" rural and remote medical practitioners. Initiatives range from programs to encourage rural high school students to consider medical careers and support for medical undergraduates through to relocation and retention grants for medical practitioners. The continuum of initiatives is described by RDN as the "RDN Route"[5].

The guiding principles[6] of the "RDN Route" are:

- recruiting suitable candidates for medicine - identifying, selecting and encouraging rural high school students to consider medical careers;
- supporting rural origin students entering medical courses - financially, practically and emotionally;
- providing medical undergraduates with early positive exposure to rural lifestyle and practice;
- supporting junior medical officers working in rural base hospitals;
- identifying and teaching the skills required for competence in rural practice and offering these in flexible learning modules;
- teaching these skills in a rural context (fostering confidence and promoting interest in rural practice);
- supporting (existing and future) rural practitioners in order to retain their services; and
- ensuring that medical practice in rural and remote areas is sustaining and sustainable (implies flexible and innovative modes of practice and easy "entry" and graceful "exit" for rural doctors).

For details of the full range of RDN's strategies refer to RDN's website at http://www.nswrdn.com.au.

3.2 Rural and Remote Medical Workforce

The "models for recruiting and retaining rural practitioners …have (been) developed from the perspective of a predominantly male workforce"[7]. Rural medical practice in Australia has traditionally been considered a male occupation and rural practitioners in NSW are more likely

[5] McEwin, 2000
[6] The guiding principles are based on Mark Craig's guiding principles described in his article "A Rural Practice Training Program" in Craig ML (ed), Proceedings of National Rural Health Conference, Toowoomba, February 1991, published by the Department of Health, Housing and Community Services, 1992, pp 162 - 167
[7] Wainer, 1997

to be men than women. With increasing female representation in the Australian medical workforce, however, strategies to attract females to rural practice become increasingly important. During 2000 the NSW Rural Doctors Network (RDN) surveyed rural and remote medical practitioners to determine if its medical workforce recruitment and retention strategies are likely to be as effective for female medical practitioners as for males. The results of the research and the implications for the Rural Doctors Network are presented in this Discussion Paper.

Women medical practitioners are under represented in the rural medical workforce in Australia as they are in other parts of the world. Seventeen percent of female general practitioners (GPs) in Australia work in rural and remote areas compared with 22.5% of male general practitioners[8]. In NSW in 2000, 24% of rural and remote GPs were female.[9]

The number of females in the medical workforce is growing at a much faster rate than the number of males. In 1995, 27.2% of all medical practitioners in Australia were female. (In NSW in 1999, 28.4% of medical practitioners on the NSW Medical Board Register were female[10]). In the next four to five years the percentage nationally is projected to rise to 42%[11]. In 1998 more than 53% of first year medical students in Australia were females[12]. Canada[13], the USA[14], South Africa[15] and the United Kingdom[16] report similar trends.

Australia experiences difficulties in recruiting and retaining rural and remote medical practitioners as do many other nations. More women are graduating as medical practitioners, yet women are

- less likely than their male colleagues to practice in rural and remote areas; and
- more likely to work part time or be in casual employment and less likely to share in after hours and on call rosters. Over a lifetime they will work less than their male colleagues and have more time out of the workforce[17].

It is estimated that an average female general practitioner over a lifetime will work 62.8% of the hours of an average male general practitioner[18]. Female GPs work differently from their male colleagues spending more time with patients and hence will see fewer patients in a given time[19]. Britt found that by comparison with males, female GPs tended to have longer consultations; managed significantly higher numbers of problems per encounter; saw a higher percentage of younger patients and new patients; and managed depression more often[20].

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[8] AMWAC 1996.7
[9] NSW Rural Doctors Network Database, 2000
[10] Medical Labour Force Annual Survey NSW, 1999
[11] AMWAC 1996.7, p 1
[12] AMWAC 1998.4
[13] Birenbaum 1995
[14] Collins et al 1997
[15] Moodley et al 1999
[16] AMWAC 1996.7, p 20
[17] AMWAC, 1996.7;
[18] AMWAC, 1996.7,p11
[19] Department of Health and Family Services, 1996, p60
[20] Britt, 1999

The Australian Medical Workforce Advisory Committee (AMWAC) study[21] examining key influences on participation decisions found that male and female medical practitioners have different career drivers. For males they are associated with the professional work ethic and achieving a high standing amongst their peers, while for females the career ambitions were generally modified by the priority they place upon the development and maintenance of personal and family relationships and the requirement to balance family responsibilities with their clinical work. Female practitioners tend to be the main family carers.

The increasing representation of female medical practitioners is a major confounding factor for rural medical workforce planning. The shortage of rural and remote medical practitioners will become worse unless special measures are taken to attract and retain women practitioners to rural practice. Drawing on AMWAC studies, Horvath et al (2000) recently wrote "as the proportion of women in medicine increases the magnitude of the problem of maldistribution could increase. In Canada and the United States, it is proposed that there is a need for innovative strategies to make rural practice more attractive to women doctors"[22]. "Medical workforce participation rates are similar in Australia to those occurring in other developed countries…it is important that .. appropriate workforce policies and strategies can be developed"[23].

Females are more likely to become GPs (family physicians) than other medical specialists. 61% of GP registrars are now female[24]. This is significant as GPs make up the majority of all medical practitioners working in rural and remote Australia - 60.2% in 1998[25]. Many young male doctors are also indicating that they would prefer to work in "family friendly ways"[26]. One important finding from the 1996 and 1998 AMWAC studies[27] and the National Rural General Practice Study[28] was that there were significant differences in priorities and preferences not only of women graduates but also of all recent graduates, compared with the whole group of rural and remote general practitioners. In particular, women and younger male rural medical practitioners rate practice style and lifestyle issues such as hours worked each week, practising public health, availability of continuing medical education (CME) and availability of leave as being significantly more important than do their older male counterparts. Clearly, conventional models of rural practice involving long hours on call, and the emphasis on hospital-based procedural services, are not necessarily attractive to recent graduates as a whole. The strategies designed to attract females to the rural workforce are also likely, therefore, to appeal to recent male graduates.

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[21] AMWAC, 1998.4
[22] Horvarth et al, 2000, p36
[23] Horvarth et al, 2000, p35
[24] RACGP, 2000, p1
[25] AIHW 2000, p 4
[26] Personal communication and exit interviews conducted with NSW Rural Resident Medical Officer Cadets (interns and RMOs at NSW rural base hospitals) in December 2000 confirmed the intention of many young male rural doctors to work more reasonable hours than older male doctors. The younger doctors indicated that they had observed too much "burn out" among their senior male colleagues.
[27] AMWAC 1996.7 and AMWAC 1998.4
[28] Strasser et al, 1997

3.3 Aim of RDN's Research

RDN's research aims to determine if the initiatives that have been introduced to attract and retain rural and remote medical practitioners in one state of Australia, New South Wales (NSW) are likely to be effective for female medical practitioners. In particular, the research surveys

1. work practices and attitudes and differences between females (general practitioners and specialists) and males (general practitioners) and
2. the impact on recruitment and retention strategies.

4. RDN's Surveys of Female and Male Medical Practitioners working in Rural and Remote NSW

4.1 Methodology

In May and June 2000 all female general practitioners and all female specialists residing and working in rural and remote NSW were surveyed. A matched randomly selected cohort of male general practitioners was surveyed in August 2000. There were 302 female GPs and 96 female specialists. The randomly selected cohort of male GPs comprised 302 practitioners and was not stratified. The surveys were conducted using a seven page questionnaire (Appendix A) sent by mail accompanied by a covering letter and a self addressed and stamped envelope to return the questionnaire to RDN. The female and male GPs were identified from the RDN workforce database. The Australian Medical Publishing Company (AMPCo) provided the list of female specialists. The responses were analysed using the software package SPSS (Statistical Package for Social Sciences).

5. Survey Results and Discussion

5.1 Response Rates

Sixty seven percent of female general practitioners responded; 48% of female specialists; and 41% of male general practitioners.

5.2 Geographic Distribution

As rural NSW is heterogeneous, in considering whether or not the responses could be regarded as representative and therefore valid samples, the distributions of the respondents for the three sample groups were examined against their population distributions. The samples of female and male general practitioners, examined by Rural, Remote and Metropolitan Areas Classification (RRMA)[29], mirrored the population distributions. The general practitioner respondents were spread across all seventeen rural Divisions of General Practice and hence again could be considered representative samples. Specialists do not belong to Divisions of General Practice. An examination of the spread of specialist respondents, however, revealed representation from all areas covered by the rural Area Health Services with the exception of the Far West Area Health Service. Specialists practised and resided predominantly in RRMA 3 and RRMA 4 towns. The specialties represented are: anaesthesia, cardiology, dermatology, emergency medicine, geriatric medicine, general medicine, obstetrics and gynaecology, oncology, opthamology, orthopaedics, palliative care, pathology, paediatric medicine and paediatric surgery, psychiatry, radiology, rehabilitation medicine, renal medicine and rheumatology.

[29] Department of Primary Industry and Energy, Department of Human Services and Health, Rural, Remote and Metropolitan Areas Classification, November 1994

5.3 Age

The age profiles of the three groups are similar (Figure 1). In all three samples most respondents are baby boomers in their forties. The female GPs are evenly spread across the age groups 44 – 45 years and 46 – 50 years. The female specialists have a high percentage in the 36 – 40 year age group and more male GPs are 46 – 50 years old.

Figure 1 - Age Distribution

(graph to be inserted here by Angela)

5.4 Rural versus Non Rural Origin

Rural origin means that the respondents were raised in rural areas. "Rural" was determined by the respondents and included rural areas overseas as well as interstate. The percentage of medical practitioners raised in rural areas is high. Thirty four percent of female general practitioners, 33% of female specialists and 43% of male general practitioners were raised in rural areas (Table 1). At the time that the respondents were undergraduates, programs to encourage rural students to study medicine (such as high school programs to encourage medical careers, rural entry schemes for medicine, scholarships for rural students) had not been introduced. Programs to encourage rural exposure were in their infancy (NSW Health introduced the NSW Rural Resident Medical Officer Cadetship Program in 1989 and travel and accommodation subsidies for medical undergraduates on rural electives in 1990.) Recruitment and retention strategies are predicated on rural background and positive rural exposure being significant factors in subsequent decisions to practice rurally[30]. As Wainer has stated, the research that underpins recruitment and retention strategies has been done on a predominantly male data set[31]. The RDN research suggests that rural background is an important factor influencing both males and females to practice rurally. Compared with male GPs, female rural origin representation is lower – possibly because the women are more likely to follow their male spouses than vice versa (Section 5.10).

Table 1 - Rural Origin versus Non Rural Origin

	Raised in a rural area*	**Not raised in a rural area**
Female GPs	34%	66%
Female Specialists	33%	67%
Male GPs	43%	57%

* rural area is defined by respondents

5.5 Marital Status

The three groups have similar marital status profiles with 86% of female GPs, 91% of male GPs and 78% of female specialists being in married or defacto relationships (Table 2). That the

[30] Cooper et al, 1997; Carline et al, 1980; Ernst and Yett, 1985; Rabinowitz, 1988a; 1988b; 1990; Easterbrook et al, 1999, as referred to by Levitt 1999

[31] Wainer (November, 2000) personal communication

specialists are less likely to be married or in defacto relationships probably reflects their slightly younger age profile.

Table 2 - Marital Status

	Married/defacto relationship	Not married/defacto*
Female GPs	86%	14%
Female Specialists	78%	22%
Male GPs	91%	9%

* single, separated or divorced, widowed

5.6 Spouse Occupations

A high number of medical practitioners are married to other medical practitioners – 42% of female GPs, 61% of female specialists and 29% of male GPs (Figure 2). Generally a high number are married to professionals. Almost one third of female GPs interviewed by AMWAC[32] had medical partners so the female GP result is within expectation. The number of female specialists married to other medical practitioners is high compared with female and male GPs. It would be interesting to explore this further. Compared with male GPs, more females were married to, or in defacto relationships, with a higher percentage of professionals.

Figure 2 – Spouse Occupations

(graph to be inserted here by Angela)

5.7 Medical Practitioners with Children

The percentages of female and male general practitioners with children are similar – 87% and 93% respectively (Table 3) and very similar to the percentages of female and male general practitioners in married or defacto relationships. The female specialists have a lower percentage with children – 65%. This may reflect that a higher percentage are still in the childbearing age group and maybe are yet to have children.

Table 3 – Medical Practitioners with Children

	With children	Without children
Female GPs	87%	13%
Female Specialists	65%	35%
Male GPs	93%	7%

[32] AMWAC 1998.4

5.8 Age of Children

The spread of the children of medical practitioners across preschool, primary school, secondary school and post secondary school age is presented in Figure 3. Approximately three-quarters of the children of the female GPs and specialists are yet to go to school or still at school, compared with just over half of the children of male GPs. Female specialists have a higher percentage of preschoolers compared with female and male GPs (reflecting the younger age cohort of the specialists?). More male GPs have children who have left school than have either the female GPs or the female specialists. The implications of having children still at school or yet to go to school are explored in Section 5.9.

Figure 3 – Age of Children

(graph to be inserted here by Angela)

5.9 Responsibility for the Care of Children

There are clear differences in the way female and males assign responsibility for raising children. Seventy eight percent of female GPs and 47% of female specialists have the main responsibility for the care of the children (Table 4). A greater percentage of female specialists (37%) share the responsibility for caring for children with their partners, than do female GPs (10%). Only 7% of female specialists and 6% of female GPs with children do not have the main or shared responsibility for caring for children. Section 5.8 has described the differences in the ages of the children of the surveyed medical practitioners. More than two thirds of female GPs' children and more than three quarters of female specialists' children are at school or yet to go to school. This compares with approximately half of the male GPs' children. Generally children at school and especially those yet to go to school require more looking after than those who have left school. The children of male GPs are likely to be older, and possibly require less looking after. This is inconsequential, however, if the males are unlikely to have primary responsibility for raising children. Unfortunately, due to error, the wording on the survey form for the male GPs did not ask them who specifically carried the main responsibility for the care of children. This analysis therefore draws upon AMWAC research.

AMWAC found that 95% of female interviewees (GPs and specialists) with children carried the main responsibility in their household for the care and rearing of children. Most indicated that they continued to work after the birth of their children, usually in a part time capacity. The AMWAC findings suggest that female specialists return to medical practice following the birth of a child sooner than do female GPs[33]. This may explain the greater percentage of specialists in the RDN survey who have shared responsibility with their partners for caring for children. It may also reflect the younger age cohort of specialists and possibly a higher number of them in less traditional role defined relationships.

[33] AMWAC 1998.4

In the AMWAC study male medical practitioners rarely carried the main responsibility for the care of children[34]. Compared with female interviewees, male interviewees were less likely to mention that having a family had influenced their career decisions in any way, either negatively or positively.

The high percentage of female general practitioners as primary carers has major implications for the way that women practice medicine.

Table 4 – Main Responsibility for the Care of Children

	Main responsibility	Shared responsibility	Do not have main responsibility	Children are adult
Female GPs	78%	10%	6%	6%
Female Specialists	47%	37%	7%	10%

5.10 Why chose Rural or Remote Practice?

Lifestyle and attraction to rural practice are the main reasons for choosing rural practice (Table 5). Attraction to lifestyle is given by more female GPs and female specialists than any other reason. Seventy four percent of specialists stated that lifestyle was the reason for being in rural practice compared with 47% of female GPs (the same percentage of male GPs gave lifestyle as the reason). More male GPs gave attraction to rural practice as the reason than lifestyle – 53% compared with 47%. Attraction to rural medicine is the equal second reason given by female GPs (38% gave "attraction to rural medicine" and 38% said "husband's choice") and by female specialists (26%). Nearly 40% of the females are in rural practice because they have followed their husbands to a rural or remote area. This means that up to 40% of female practitioners may have had no preparation for rural practice (it not necessarily being their choice). This is lower than the 1998 AMWAC study which found the figure to be 50%[35] but it is still very high and has implications for recruitment strategies and training required once in a rural area. Two percent only of the male GPs have stated that they are in rural practice because of their spouses. The same percentage is in rural practice because they followed their fathers (into the fathers' practices). Seventeen percent of female specialists are in rural practice because of their partners, lower than for female GPs but higher than for male GPs.

In analysing the reasons for choosing rural practice the responses have been grouped into categories. "Attraction to lifestyle" includes statements such as "hated living in Melbourne – concrete jungle", "nicer environment", "affinity with rural lifestyle/people". Attraction to rural practice includes comments such as "ability to perform full range of medical skills", "variety of medicine and extra responsibilities e.g. able to look after patients in hospital", "challenging job", "closer patient doctor relationship", "job satisfaction", "wider scope for procedural work".

[34] Ibid
[35] Ibid

"Marriage/spouses choice includes "I didn't choose (rural practice) – my husband did!", "Husband got a job in (name of town)".

The findings of the RDN surveys are consistent with the 1998 AMWAC study that found that female medical practitioners are more likely than male practitioners to have altered their initial career choices in order to accommodate the careers of their spouses/partners. This is most evident in terms of decisions about occupation and training, hours worked per week *and location of work*.[36] In comparison with female medical practitioners, more male practitioners reported that spouse/partner considerations had no effect on their career decisions**.** The AMWAC study found that for males, the most common reason for choosing rural practice was growing up in a rural area, with positive rural experience running second. This is different from the RDN survey that found attraction to rural practice to be the most important reason. For females, AMWAC found that the most common reason for working in a rural environment was their partner's job. Both male and female practitioners described the pleasures of the rural lifestyle and the scope of rural practice as important factors in remaining in rural practice.

Table 5 – Reasons for Choosing Rural Practice

Reason (responses are grouped* and are not mutually exclusive)**	**Female GPs**	**Female specialists**	**Male GPs**
Attraction to lifestyle	47%	74%	47%
Attraction to rural practice (more challenging/interesting)	38%	26%	53%
Marriage/spouse's choice	38%	17%	2%
Extended family/better for children/be close to family	14%	7%	2%
Rural exposure	8%	-	21%***
Workforce need	-	17%	
Career reasons (such as appointment)	-	7%	
Following father	-	-	2%

* Many respondents gave more than one reason
** For example "attraction to lifestyle" can assume rural exposure
*** "Rural exposure" in the male responses sometimes assumes rural origin. In fact 43% of male GPs are rural origin (Table 1).

5.11 Hours of work

As expected more women than men work part time (Table 6). Part time is defined as less than 40 hours per week and is consistent with the AMWAC definition of part time hours of work[37]. The hours of work varies considerably above and below the 40 hour cut off point. The major reason that more women than men work part time is that they are much more likely to have

[36] Ibid
[37] AMWAC 1996.7 p.11

responsibility for looking after the children (Table 4). The percentage of female specialists working part time (50%) is similar to the percentage of female specialists with the main responsibility for the children (47%). The percentage of female GPs working part time (61%) is less than the 78% who carry the main responsibility for the children. Only 11% of male GPs are working part time.

Table 6 - Part time & Full time Work

	Full Time	Part Time*
Female GPs	39%	61%
Female Specialists	50%	50%
Male GPs	89%	11%

*Part time is defined as less than 40 hours per week and is consistent with the AMWAC definition of part time hours of work.

5.12 Satisfaction with Working Hours

It is disturbing that overall almost half of the medical practitioners have indicated that they would prefer to work a different number of hours – in nearly all cases preferring fewer hours (Table 7). The majority of female GPs sampled are satisfied with current working hours. This probably reflects that more of them are already working part time (Table 6). The female specialists are more likely to prefer fewer hours than female GPs (fewer work part time). The male GPs are least content with their hours.

Table 7 – Satisfaction with Working Hours

	Satisfied with current hours	Prefer fewer hours	Prefer more hours
Female GPs	56%	41%	4%
Female Specialists	43%	52%	55%
Male GPs	36%	62%	2%

The reasons preventing the respondents from working their ideal hours, in this case fewer hours than they now work, were given as follows:

- female GPs – staff shortage/patient demand (including lack of locums) (37%); career commitment and expectation of the community and colleagues (31%); financial issues (27%);
- female specialists - patient demand/workforce shortage (including lack of locums) (65%); financial reasons and patient workload (7%); being unable to shed on call (2%); commitment to continuity of care (2%); training (2%); financial reasons alone (2%)
- male general practitioners - related to either the GP workforce shortage/their professional responsibilities to their patients (64%); or to financial reasons (36%).

5.13 Planning to leave their Current Practices

Fewer of the female GPs are planning to leave their current practices in the next five years than both female specialists and male GPs (Table 8). Twenty six percent of female specialists and 21% of male GPs are planning to leave their current practices in the next five years. Nineteen percent and 20% respectively are undecided. Taking both the "definite about leaving" and the "undecided" respondents for the female GPs, female specialists and the male GPs and a picture emerges of a mobile workforce.

Table 8 – Planning to leave their practices in next five years

	Planning to leave	Not planning to leave	Undecided
Female GPs	16%	62%	22%
Female Specialists	26%	55%	19%
Male GPs	21%	59%	20%

5.14 Professional Development/Continuing Medical Education

Female general practitioners and female specialists require similar things from CME (Table 9). Topics required address their personal needs and the particular circumstances they face in their every day working environments such as dealing with discrimination and role conflicts. CME is generally regarded as important for maintaining competence (ie technical skills and knowledge), yet what the females want in their CME is related to retention rather than competence as such. This is a significant shift from what has traditionally been regarded as CME. The male GP requirements (Table 10) were clinical topics, although managing "burn out" was mentioned. The topics listed in Tables 9 and 10 are not in order of frequency.

Table 9 – CME Topics required by Female GPs and Female Specialists

Topics - Female GPs	Topics - Female specialists
Dealing with discrimination (male colleagues)	Dealing with discrimination (male colleagues)
Dealing with role conflicts	Dealing with role conflicts
Dealing with difficult unsafe situations	Dealing with difficult unsafe situations
Management/ leadership and negotiation skills	Management/ leadership and negotiation skills
women's health	Supporting reentry programs
Counselling	Self esteem, dealing with confidence issues
financial skills	Computers

Table 10 – CME Topics required by Male GPs

Topics required by Male GPs
Discussion of managing "burn out"/surviving demanding working hours and long hours
Managing depression and mental illness
Stress management
Financial and time management
Population health
Obesity/weight management, ENT disorders, STD updates, major trauma
Aboriginal health
Attention Deficit Disorder
Dermatology
Microbiology, immunology, arrythmias, cancer genetics, respiratory disease
Anaesthetics, obstetrics
Strictly clinical and medical CME

5.15 Major Issues faced by Rural and Remote Medical Practitioners

The survey has highlighted a number of differences between the male and the female medical practitioners in their attitudes to rural practice, the way they practice medicine and the major issues that they face as rural practitioners. The issues that the females face as rural practitioners are remarkably similar regardless of whether they are general practitioners or specialists (Table 11). The question was asked as an open ended question. The responses are grouped.

The major issues for the female GPs (in order of the frequency with which they were raised) are:
- role conflict in having to balance family and professional responsibilities
- lack of accessible childcare especially for after hours and emergency care.

For the female specialists these issues are high but higher are:
- professional and social isolation and
- meaningful and accessible CME and opportunities for flexible training.

The lack of flexible work opportunities is high for both female general practitioners and specialists. A lesser percentage of female specialists raised role conflict as an issue compared with the female GPs. This may be because fewer specialists than female GPs have primary responsibility for the raising of children – more specialists have shared responsibility. More specialists were concerned about discrimination from male colleagues than were female GPs. Fewer specialists were concerned about spouse issues than were female GPs. This may reflect the greater degree of shared responsibility for children. It may also reflect that more specialists are married to medical practitioners and are therefore not likely to encounter employment difficulties for their spouses. Issues with a frequency below 9% are not included in Table 11. They included issues such as looking after one's own health, the high cost of medical indemnity, and lack of cultural environment. The female specialists were asked if they face issues as female specialists over and above being female medical practitioners. There were few issues identified but those that were related to the greater difficulty that specialists have in accessing

CME/professional development (which is predominantly city based), and the fact that there are fewer female specialist colleagues in the country, hence professional isolation is exacerbated.

Table 11 - Major issues faced by Female GPs and Female Specialists

Issue raised	% Female GPs who raised the issue	% Female specialists who raised the issue
Role conflict (balancing work and family)	39%	24%
Lack of childcare	39%	30%
Lack of flexible work opportunities	31%	35%
More appropriate CME and flexible training	31%	46%
Professional and social isolation	42%	52%
Spouse issues	20%	9%
Children's education	18%	11%
Discrimination from male colleagues	18%	28%
Community expectations on them as women	17%	20%
Locums (including need for female locums)	14%	9%

The major issues faced by the male general practitioners (Table 12) are different from those faced by the females (Table 11). Again the responses are grouped. The long hours combined with the heavy patient load was the major issue identified by the males, followed by inadequate remuneration and the high costs associated with rural practice. Relationships with the Area Health Services were strained, with concerns about the downgrading of facilities especially for procedures. This and "government interference" were identified by 38% of the males as major issues, falling just short of the concern about long hours and heavy patient load. Issues with frequencies below 9% are not included in Table 12.

Table 12 - Major issues faced by Male GPs

Issue raised	% Male GPs who raised the issue
Long hours/overwhelming patient load (including after hours)	42%
Inadequate remuneration / high costs etc	29%
AHS issues/down grading hospital services etc	23%
Children's schooling	19%
Availability and cost of locums	19%
Lack of peer support and isolation	19%
Pressure on family life and lack of spouse job opportunities	18%
Too few GPs/workforce crisis etc	17%
Government interference	15%
Lack of Specialist backup etc	14%
Distance learning opportunity and CME opportunities	13%
Medico legal issues	12%
Encourage increase in procedural skills & maintenance of skills	12%
Heavy responsibility + poor community understanding	10%

5.16 Changes recommended to improve Recruitment & Retention Rates

The responses from the female medical practitioners to improve recruitment and retention rates (Table 13) are consistent with the issues they identified in Table 11. A large number of suggestions are made but with slightly different priority ratings (possibly because the more practical suggestions take precedence). The changes recommended include:

- addressing the lack of flexible working and training opportunities;
- providing childcare for all occasions (regular working hours, after hours and emergency work);
- providing more meaningful CME in more readily accessible ways;
- addressing the loss of confidence women suffer in re-entering the workforce after time out for caring for children or other family members;
- more accessible and flexible education;
- providing support mechanisms to overcome professional and social isolation; and
- providing locums (including female locums so that the patients wanting to see "a lady doctor" don't wait for the return of the female GP).

The changes that are recommended by female GPs and female specialists are grouped and listed in order of frequency. The recommended changes with frequencies below 9% are not included. Of interest is that female specialists did not explicitly state the need to address the role conflict of balancing professional and family responsibilities although nearly one quarter of them mentioned it as a major issue. Their suggested changes do, however, address this implicitly in recommending flexible working and training opportunities (recommended by 31% of specialists), the need for childcare for all occasions (frequency = 31%), and more appropriate and accessible CME (frequency = 22%).

Table 13 – Changes recommended by Female GPs and Female Specialists to improve rural recruitment and retention rates

Change suggested	% Female GPs who suggested the change	% Female specialists who mentioned the change
Addressing the lack of flexible working and training opportunities	22%	31%
Childcare for all occasions	21%	31%
More appropriate and accessible CME/ dealing with loss of confidence in re-entering the workforce/ access to flexible education	19%	22%
Positive rural exposure/encouraging rural origin females to enter medicine	18%	30%
Overcoming professional and social isolation through support networks etc	15%	24%
Providing locums including female locums	15%	15%
Addressing the role conflict of balancing work and family	14%	-

Supporting women with spouse issues	12%	17%
Dealing with male discrimination/changing male dominated culture	12%	11%
Better education opportunities for children	11%	15%
Tax incentives/financial incentives such as relocation grants, tax breaks	-	20%
Support from teaching hospitals	-	9%

The major changes recommended by the male practitioners to increase the rural medical workforce (Table 14) reflect the male issues (Table 12) and are different from the changes recommended by the females (Table 13). Almost half the male GPs recommend increased remuneration to improve recruitment and retention rates. This was not a change recommended by female GPs though 20% of female specialists recommended financial incentives. Rural specialists, unlike rural and remote general practitioners, do not currently receive financial incentives for being in rural practice. Rural and remote GPs receive grants through the Commonwealth's Rural and Remote General Practice Program and have specific fee for service arrangements through the NSW Rural Doctors Settlement Package. Changes with frequencies less than 9% are not included in Table 14. Less than 1% of the male GPs suggested improved childcare arrangements compared with 21% of female GPs and 31% of female specialists. Only 4% of males requested better peer support arrangements to overcome social and professional isolation compared with 15% of females GPs and 24% of female specialists.

Table 14 - Changes Recommended by male GPs to improve Recruitment and Retention

Change suggested	**% Male GPs who suggested the change**
Increased remuneration	46%
Funded locums	22%
Rural exposure for medical undergraduates and postgraduates	21%
Less bureaucracy	14%
Support for rural origin students including rural entry schemes for medicine students	13%
Lifestyle issues – decreased hours on call relief	13%
CME	9%

One important finding from the survey of male GPs is how closely aligned the changes that they recommend to improve recruitment and retention rates are *with the recruitment and retention strategies that are currently in place in NSW* (Table 15). This is not the case for the female medical practitioners.

Table 15 - Changes recommended by male medical practitioners and recruitment and retention strategies currently in place in NSW

Recommended changes	Initiatives funded and/or administered by RDN in NSW
Increased remuneration[38]	▪ Relocation and retraining grants ▪ Retention grants ▪ Remote area grants ▪ Sustainable practice grants
Locum services	▪ Locum subsidies provided through RDN and Divisions of General Practice
Rural exposure for medical undergraduates and postgraduates	▪ Accommodation and travel grants for rural placements ▪ Scholarships such as Bush Bursary, CWA, regional development board and industry scholarships ▪ Rural Health Scholarships Database ▪ Rural Health Clubs ▪ Cadetships ▪ Working with overseas trained doctors to provide them with training and support in rural environments
Support for rural origin students[39]	▪ Rural High Schools Careers Projects
Lifestyle issues – decreased hours on call etc	▪ Included in many initiatives eg sustainable practice, family friendly CME conference, working with local government
CME	▪ RDN Rural Refresher conferences ▪ Satellite programs ▪ Procedural weekends ▪ Funding to Divisions of GP for CME

It is reassuring that the changes recommended by the male GPs are so closely aligned with current strategies. This suggests that the recruitment and retention strategies in place in NSW to recruit and retain rural and remote medical practitioners are appropriate for the majority of the medical workforce.

[38] The NSW Rural Doctors Settlement Package (agreement between the Rural Doctors Association, NSW and NSW Health) recognises the particular circumstances of rural GP Visiting Medical Officers working in NSW rural hospitals by providing a fee for service arrangement and obstetrics and anaesthetics grants.

[39] Rural Entry Schemes for medicine at the Universities of Newcastle and NSW are initiatives in this area

6. Recommendations

The findings from the surveys have highlighted a number of differences between male and female rural and remote medical practitioners in the way that they practice medicine, their attitudes to rural practice and the major issues they face as rural and remote practitioners.

The findings suggest that additional strategies are required to improve recruitment and retention rates of female rural and remote medical practitioners. Emerging from the research findings, therefore, are recommendations designed to improve recruitment and retention rates for female practitioners. Recommendations targeted at females are, however, likely to be attractive to recent male graduates wanting to adopt more "family friendly" modes of practice. As one rural male GP wrote "(The) main problems are domestic with the husband (or wife) being away from home for longer hours than city counterparts and being away for emergencies at important times for the spouse and family. This creates home pressures…"[40]

An important finding from the survey of male GPs is that their recommended changes are closely aligned with recruitment and retention strategies already in place in NSW (Table 15). The similarity between the male responses and the existing initiatives is reassuring. It confirms that the recruitment and retention strategies in place in NSW are appropriate for the majority of the current rural and remote medical workforce. Nonetheless, improvements can be made and recommendations are included that are targeted at both female and male medical practitioners.

There is a multiplicity of reasons why women are under represented in the rural medical workforce (ie issues of recruitment) and there are also special issues for women that need to be addressed to encourage retention. Four major themes emerge from the responses of female medical practitioners. These are:

- The role conflict that the women experience - balancing work and family life – Female rural and remote medical practitioners have the major responsibility for the care of the children. 78% of female general practitioners and 47% of female specialists have sole responsibility for the care of the children. 10% of female general practitioners and 37% of female specialists share the responsibility with their husbands/partners. Male general practitioners do not as a rule have responsibility for the care of the children. This is a significant difference between the males and the females. An issue, particularly for female GPs, is the need to balance professional and family commitments. By contrast male rural medical are unlikely to mention their families at all when interviewed about their medical practice.[41]

- The need for flexible practice and training opportunities – Female GPs and female specialists want flexible working and training arrangements - part time and job sharing opportunities, salaried as well as private practice arrangements, on call and after hours arrangements which do not compete with them as the primary family carers. Inflexibility discriminates against women for the reasons associated with the role conflict.

[40] Male GP, RDN Research Survey Form, 2000
[41] AMWAC 1998.4

- The desire for support networks to overcome social and professional isolation –and linked to this is CME to be responsive to the issues that affect them as female practitioners. They require CME that addresses the issues they face everyday – dealing with role conflicts, discrimination, difficult or unsafe situations, dealing with lack of self esteem and difficulties associated with returning to practice after time out caring for children, obtaining management and leadership skills. They are wanting formal and informal social and professional support groups and networks established.

- Spouse Issues – Women tend to follow their spouses. The survey found 38% of the female general practitioners are in the rural or remote workforce because of their spouses or husbands. This is lower than a 1998 national survey conducted which found the figure to be 50%[42] but it is still very high and has implications for recruitment strategies and for training once in a rural area. By comparison only 2% of the male GPs were in rural practice because of their spouses (the same percentage that were in rural practice because of their fathers!).

Female GPs do not want to feel guilty or feel like "not a real rural doctor" because they work part time. One female GP lamented "the perception of male colleagues is that part timers are not worthwhile… are not real doctors". Another said "(I want) to embrace part time work and not feel guilty. All doctors need to be encouraged to have shorter hours to equalize work pressure". Another wrote "the difficulty of finding a part time job that is really part time … Juggling on call and family commitments… this also applies to my male colleagues who are equally frustrated at never seeing their families".

Recommendation 1: (A) RDN actively promotes policies that encourage flexible working arrangements that take into account family responsibilities; and **(B)** RDN identifies part time, job share positions and salaried positions in rural and remote areas including part time Visiting Medical Officer (VMO) appointments at Area Health Services; and also **(C)** local councils, health services, communities and rural Divisions of General Practice promote these positions.

Recommendation 2: RDN and the Rural Medical Training Forum (RMTF)[43] actively promote policies that encourage flexible training arrangements that take into account family responsibilities, including the development of formal links to this end with the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practice (RACGP) and the new regional consortia for general practice training.

Recommendation 3: (A) RDN actively promotes policies that encourage further flexible training and working arrangements that take into account family responsibilities for junior medical officers at rural base hospitals; and **(B)** RDN identifies part time, job share positions and salaried positions available for junior medical officers and also that Area Health Services and NSW Health promote these positions.

RDN supports medical practitioners by providing professional development/continuing medical education through four to five statewide Rural Refresher conferences a year. RDN already

[42] Ibid

[43] The Rural Medical Training Forum is the coordinating forum in NSW for all matters relating to rural medial education and training and includes representation from all key stakeholder organisations.

includes topics beyond those considered strictly clinical. This was in response to the findings from the female GP survey and also in response to feedback from previous conferences.

Recommendation 4: RDN continues to provide presentations *at each* Rural Refresher conference on the topics requested by the female medical practitioners with considerations made for family commitments. Topics offered should include: dealing with discrimination; dealing with role conflicts; dealing with unsafe situations; management and negotiation skills; dealing with low self esteem and skills to assist in returning to practice after time out; dealing with depression, stress and discrimination.

Recommendation 5: A target is set for 50% of the presenters at RDN's Rural Refresher conferences to be female. This sends a positive message to younger female medical practitioners and female medical students attending the conferences.

RDN also holds one "topic specific" conference annually on surgery, anaesthetics or obstetrics. The number of places available at these conferences is limited to provide intensive hands on learning.

Recommendation 6: As part of RDN's policy of holding annual "topic specific" conferences, it is recommended that RDN organises one additional conference per year on leadership skills for female rural practitioners. Women medical practitioners remain under represented on boards and committees and this would be a positive step towards addressing the imbalance. It also sends a positive message to younger female medical practitioners and female medical students.

RDN also supports existing rural medical practitioners by providing locums. The findings from the women's surveys recommend that RDN provides additional locums including for cover such as after hours and on call, which can be so difficult for women with care of children. Female locums were also requested. The comment was made by some that if the locum is a male the patients will often await the return of the female medical practitioner. "The need for lots more female GPs because of patient demand for 'a lady doctor'."

Recommendation 7: RDN and the Rural Medical Support Forum[44] (RMSF) actively pursue the recruitment of additional female GP locums and subsequently advertise their availability to female GPs.

Through the Rural and Remote General Practice Program (RRGPP) [45], RDN offers retraining grants to rural general practitioners. In 1999/2000 twenty grants went to males and eight grants to females. From 1 July 2000 – 30 December 2000 nine grants went to males and four grants to females. In terms of the population ratio of males to females, the female representation is

[44] The Rural Medical Support Forum is the major advisory body that provides RDN with strategic advice and information on issues relating to improving recruitment, retention and sustainability of the rural and remote medical workforce. The Forum comprises representatives of local government, community, rural GPs, Divisions of GP, federal and state health departments and is chaired by RDN.

[45] The Rural and Remote General Practice Program is funded by the Commonwealth Department of Health and Aged Care and administered in NSW by RDN.

acceptable. Nevertheless RDN's research indicates that females could benefit from broadening the scope of the retraining grants to include, for example, re-entry grants.

Recommendation 8: (A) RDN and the RMSF broaden the scope of the retraining grants offered through the Rural and Remote General Practitioner Program (RRGPP) to include "re entry to the medical workforce" grants and further, that the criteria for all retraining grants be made more flexible to encourage more women to take advantage of the grants. **(B)** It is also recommended that childcare costs (as required) be covered by the retraining grants.

The women practitioners feel isolated professionally and socially. One female GP wrote that for her the major issue of being a rural practitioner was the "lack of contact with other female medical practitioners in a similar situation (ie with young children) – nearest group is (major centre) but night meetings are hard to get to as one and a half hours travel time." This sentiment was echoed many times.

Recommendation 9: RDN (through its RRGPP Sustainable Practice grants), funds Division(s) of General Practice, to establish two pilot female support groups – one being via face to face meetings and the other being via teleconferences. Successful models already exist within at least two Divisions of General Practice. RDN should also support additional Divisions if they express interest in establishing support groups.

Recommendation 10: RDN establishes a pilot Statewide email forum for women doctors. The Forum could include a monthly newsletter incorporating news of activities of women's support groups as well as information likely to be of interest to female practitioners. Those doctors unable to easily access email messages could be sent hard copies of the newsletters.

Childcare is a big problem for female practitioners. As one female GP responded when asked about the major issues: "the obvious – childcare clashing with on call commitments". Local governments and communities offer houses, surgeries and vehicles to attract doctors to their communities but few think to offer family help or childcare.

Recommendation 11: RDN, working with rural Divisions of General Practice, actively encourages all types of childcare (ie routine, after hours, emergency etc) being available for female doctors. This includes working with the Country Women's Association, local government, local health services and other stakeholders to provide local childcare.

Recommendation 12: RDN examines *all* its current recruitment and retention strategies to ensure that they actively target women as well as men. In particular, initiatives have recently been introduced as a consequence of the Federal and NSW Health Ministers' agreement on overseas trained doctors (OTDs). RDN manages most of these initiatives in NSW and must ensure that the initiatives address the issues of female OTDs.

The female practitioners also had suggestions about improving recruitment rates through supporting female undergraduates. "….My colleagues reckon the answer to attracting women doctors to the bush is handsome men and preferably ones who can cook. Mine was good looking once but 20 years of rural surgery has turned him into a tired 50 year old".

Recommendation 13: (A) RDN researches (or participates in collaborative research) the attitudes of female and male medical undergraduates towards rural practice (this will inform future recruitment strategies); **(B)** RDN works with the three NSW Medical Schools and the RMTF to offer female medical students the opportunity to be placed with female rural practitioners on rural placements; and **(C)** RDN continues to support Rural Health Clubs, in particular their gender initiatives.

The AMWAC studies and the National Rural General Practice Study findings demonstrate that the younger cohort of male medical graduates are no longer wanting to work like the older male rural GPs.

Recommendation 14: RDN researches (or participates in collaborative research) the attitudes of female and male junior medical officers working in rural base hospitals to determine how similar or different the attitudes of young male and female medical practitioners are in NSW to rural practice.

Recommendation 15: RDN undertakes a prospective study to monitor and report on career decisions made by medical undergraduates holding RDN cadetships, Bush Bursaries and the Country Women's Association (CWA) scholarships and the factors influencing them in their workforce decisions.

The findings of the surveys indicate that an alarming percentage of medical practitioners are unhappy with the number of hours that they are working. The percentage of males actually satisfied with their hours is the lowest of the lot – only 26% are currently satisfied. Forty three percent of female specialists and 55% of female general practitioners are satisfied. The dissatisfaction is in all but a handful of cases because of *too many hours*. That female GPs work fewer hours than either of the other two groups is likely to be a significant factor in their relatively higher level of satisfaction. Sixty one percent of female general practitioners surveyed are working part time compared with 11% of the males. Fifty percent of female specialists work part time. A major barrier preventing the three groups from working their ideal hours, in this case fewer hours, is the workforce shortage of rural and remote medical practitioners.

The findings of the research show that almost half of all medical practitioners intend to, or may leave, their current practices within five years. This confirms that the rural medical workforce is a very mobile workforce. No longer are doctors going into rural practice for the rest of their working lives. The future rural medical workforce will be unstable if there is no succession planning in place for continuing provision of medical services. RDN's workforce strategies are predicated on the principle of "ensuring that medical practice in rural and remote areas is sustaining and sustainable (which) implies flexible and innovative modes of practice and easy entry and graceful exit for rural doctors"[46].

Recommendation 16: RDN, in consultation with rural Divisions of General Practice, prepares formal guidelines, which include appropriate checklists, for communities and health services to encourage succession planning for medical services. This could be prepared under the auspices

[46] The "RDN Route" Guiding Principles – see McEwin 2000

of the RMSF and its distribution and promulgation funded through the Rural and Remote General Practice Program.

Recommendation 17: RDN, in consultation with the local Divisions of General Practice and other stakeholders, develops, implements and provides ongoing support for two different models of sustainable rural and remote general practice funded through the RRGPP Sustainable Practice grants-
(A) The first model would be in a small remote solo practice town and would be guided by current RDN/ RMSF activities related to sustainable models of practice. Guidelines currently exist to assist the process and the Rural Medical Support Forum actively supports such endeavors.
(B) The second model of sustainable practice is more unusual and would be based on identifying two or three *female* medical practitioners and developing a practice around their needs eg for flexible practice arrangements, retraining, childcare and so on. This model would be more likely to be located in a larger community but would involve all stakeholders and most importantly the rural Division of General Practice.

Limited opportunities for husbands/wives/partners, especially in employment, concerns both male and female respondents.

Recommendation 18: The Rural Medical Family Network (RMFN)[47] considers innovative ways to promote employment opportunities for spouses. This could, for example, include arranging low interest loans for spouses wanting to establish business enterprises.

Lest the findings from the surveys appear on the negative side – one final comment:- despite the trials and tribulations of being in rural practice – a message that does emerge from the research is that rural practice is rewarding for female and male medical practitioners.

> "Female practitioners are in great demand in rural areas and rural practice is extremely rewarding as there is the opportunity to meet and look after people from all walks of life and to observe families… The spectrum of diseases which comes through the door is a never ending source of interest and challenge"[48].

Rural practice offers the "ability to treat (your) own patients in hospital (with the) breadth of rural practice."[49] Rural practice also offers the lifestyle to go with it – "I like the outdoors, where you can play golf without waiting to hit off for a long time, and other activities like bike riding, fishing, bush walking etc".[50]

[47] The Rural Medical Family Network is funded by the Commonwealth Department of Health and Aged Care and supports families and spouses of rural and remote GPs. It is administered by RDN.
[48] Female GP respondent
[49] Male GP respondent
[50] Male GP respondent

7. Conclusion

The proportion of female medical practitioners in the medical workforce in Australia is expected to continue to increase. It is now widely recognised that males and females participate differently, with females working fewer hours over a lifetime and working in different ways. The need to balance family and professional responsibilities is often a big determinant of career choice as female medical practitioners tend to be the main family carers. Consequently they tend to select disciplines or ways of working which involve fewer irregular hours and fewer or no hours on call.

The increased representation of female medical practitioners is a major confounding factor for future rural and remote medical workforce planning. Therefore it is important to understand how the populations of female and male rural and remote medical practitioners differ – not just in modes of medical practice but in attitudes and family responsibilities.

The research undertaken by the NSW Rural Doctors Network has indicated that conventional models of rural practice involving long hours on call, and long hours in practice do not appeal to the majority of women practitioners. Females want more flexible training and work practices, as well as more accessible childcare during both regular working hours, and for on call, emergency and after hours work. Female medical practitioners want networks developed to overcome professional and social isolation, they face discrimination from male colleagues and the communities and they want accessible and appropriate professional development and CME that addresses their issues as females in the workforce.

With an ongoing rural medical workforce shortage and an increasing representation of females in the medical workforce, it is critical to have recruitment and retention strategies in place in NSW to suit the diversity of medical practitioners. Findings from the RDN surveys suggest that additional strategies are needed to attract females to rural and remote practice. Such strategies may also appeal to recent male graduates, though this is untested.

Until now, apart from childcare offered at most CME events in NSW, and the establishment of some informal female support groups, strategies haven't been targeted at the special needs or circumstances of female rural medical practitioners. Unless there are specific recruitment and retention strategies which recognise the particular issues females face and allow them to be mothers as well as doctors, the current rural and remote doctor shortage will be much worse. A number of recommendations are put forward in this discussion paper.

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