Women Doctors in Rural Australia: workforce support strategies

National report on the findings from surveys of rural and remote female GPs conducted by the Australian Rural Workforce Agencies between 2000 and 2003

December 2003

New South Wales Rural Doctors Network

General Practice and Primary Health Care, Northern Territory

Queensland Rural Medical Support Agency

Rural Workforce Agency Victoria

South Australian Rural Doctors Workforce Agency

Tasmanian General Practice Divisions (Rural Workforce Support)

Western Australian Centre for Remote and Rural Medicine

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Author

Sue Doyle (for the Australian Rural Workforce Agencies)

Correspondence

Kirsty McEwin
NSW Rural Doctors Network
Suite 5, Level 5, Airport Central Tower
241 O'Riordan Street
MASCOT NSW 2020

Phone: 02 9313 5955
Fax: 02 9313 5750
Email: kmcewin@nswrdn.com.au

OR

Contact the Rural Workforce Agency in your state or territory.

Copies of the Report can be found on the NSW Rural Doctors Network website: www.nswrdn.com.au and on the websites of the other Rural Workforce Agencies.

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Dr Felicity Jefferies	(WACRRM)
Dr Sally Roach	(WACRRM)
Dr Megan Rathbone	(TGPD)
Dr Karen Sumner	(RDWA)
Ms Jenny Fleming	(RDWA)
Mr Nigel Bond	(QRMSA)
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Glossary

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Controlled Community Health Organisations
ACRRM	Australian College of Rural and Remote Medicine
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMWAC	Australian Medical Workforce Advisory Committee
ARRWAG	Australian Rural and Remote Workforce Agencies Group
CDoHA	Commonwealth Department of Health and Ageing
CME	Continuing Medical Education
CWA	Country Women's Association
EBR	Evidence-Based Rating (scale of McDonald *et al*, 2002)
DGP	Division of General Practice
DMO	District Medical Officer
DOB	Date of Birth
FTE	Full time equivalent
GP	General Practitioner
GPPAC	General Practice Partnership Advisory Council
GPPHCNT	General Practice and Primary Health Care Northern Territory
GPRIP	General Practice Rural Incentives Program
GPRRIP	General Practice Registrars' Rural Incentive Payments
GST	Goods and Services Tax
HECS	Higher Education Contribution Scheme
ISF	Institute of Sustainable Futures
MDS	Minimum Data Set
MORPP	Medical Officer with Rights to Private Practice
NGO	Non-government organisation
NSW	New South Wales
NT	Northern Territory
OTD	Overseas Trained Doctor (program)
PSAP	Physician Shortage Area Program
QRMSA	Queensland Rural Medical Support Agency
RMFN	Rural Medical Family Network
RACGP	Royal Australian College of General Practitioners
RAMUS	Rural Australian Medical Undergraduate Scholarships
RCS	Rural Clinical Schools
RDA	Rural Doctors Association
RDAA	Rural Doctors Association of Australia
RDN	Rural Doctors Network
RDWA	Rural Doctors Workforce Agency
RFDS	Royal Flying Doctor Service
RHC	Rural Health Club
RLRP	Rural Locum Relief Program
RRAPP	Rural and Remote Area Placement Program
RRGPP	Rural and Remote General Practice Program
RRMA	Rural, Remote, Metropolitan Areas
RSES	Rural Students Entry Scheme
RUSC	Rural Undergraduate Support and Coordination
RWA	Rural Workforce Agency
RWAV	Rural Workforce Agency Victoria
SA	South Australia
SPSS	Statistical Package for the Social Sciences
TGPD	Tasmanian General Practice Divisions
UDRH	University Departments of Rural Health
US	United States
VURHC	Victorian Universities Rural Health Consortium
WA	Western Australia
WACRRM	Western Australian Centre for Remote and Rural Medicine
WIRP	Women in Rural Practice
WWAMI	Washington, Wyoming, Alaska, Montana and Idaho (program)

Executive Summary

With the financial support of the Commonwealth Department of Health and Ageing all the Australian Rural Workforce Agencies combined their collective experience and knowledge to develop a national database of the rural and remote female GP workforce. Rural Workforce Agencies conducted surveys of rural and remote female GPs between 2000 and 2003 and the results provided the elements of the national database. The database is unique in that the data was obtained using one survey tool and has resulted in the development of the first national rural and remote female GP profile.

A series of strategies are discussed that aim to increase the participation of females in the rural and remote medical workforce, and are based on qualitative information obtained from the survey responses. The ideas and opinions expressed by the female GPs are the main focus of the discussion, and links between the proposed strategies and existing initiatives are identified. It was possible to attach priority ratings to particular issues raised by the female GPs from frequency data, and the result is a comprehensive catalogue of potential recruitment and retention activities for GP support agencies.

Findings from the national surveys confirmed those of earlier researchers who have studied female specific issues in the rural and remote medical workforce over the last decade. Flexibility in the workplace, support networks, self-empowerment, being valued, accessible training, and equality, are recurrent themes in the rural and remote female GP literature. Different priorities are given to specific issues between studies that may be attributed in part to research methodologies and the research questions, but the themes pertaining to female GP recruitment and retention are essentially the same.

A brief background to this study is provided in the introduction (Chapter 1) including references to the findings from previous research on rural and remote female GPs. A summary of the latest national rural and remote GP data in the next section (Chapter 2) provides context for the female GP survey findings. The methodology section (Chapter 3) is a description of the distribution of surveys to female GPs in South Australia and the Northern Territory, with reference to previous publications by the other States' Rural Workforce Agencies for details of the distribution of their female GP surveys. The remainder of this section is devoted to descriptions of the survey format, purpose of the survey questions and collation of the responses. The main themes arising from the open-ended questions are listed in the methodology section, and the detail is contained in the results.

The data are presented as graphs and tables in the results (Chapter 4) and discussed in detail in the following section (Chapter 5). When responding to the surveys the female GPs were asked to specify the major issues for females working in the rural and remote medical workforce, and to nominate the changes they believed would improve the recruitment and retention of female GPs in rural and remote areas. The top three major issues were personal and professional isolation, accessible and affordable childcare, and the demands of the job. The females suggested that providing additional support networks would help to decrease isolation, and introducing more flexibility into the workplace, and providing childcare for after hours work and training commitments would enable females to participate in the workforce at a higher rate. The major issues and proposed changes identified by the female GPs also included children's education, partners' social and professional needs, access to flexible training and Continuing Medical Education (CME) events, attitudes and expectations of colleagues and communities, and safety in the workplace.

A detailed review of current recruitment and retention strategies is provided in the next section (Chapter 6) and a range of initiatives are described that have been developed to encourage the recruitment and retention of medical students, graduates and experienced medical practitioners to rural and remote practice. At the end of the discussion of each initiative a link is identified, where it exists, between current strategies and the female GPs' responses, to maintain the focus on female GP issues.

In the final section (Chapter 7) the themes that were listed in the methodology are used to construct a comprehensive table of recruitment and retention strategies. The table contains a catalogue of current general GP workforce activities to be used as models for future initiatives for rural and remote female GPs, and reflects the national female GP survey findings. Proposals for potential solutions or actions are included in the table, and are coupled with the female GPs' responses. Stakeholders are identified in the table who are involved in the support of rural and remote medical practitioners, and may recognise a role for themselves in developing some of the ideas as recruitment and retention strategies.

Chapter 1 Introduction

In 2000 the New South Wales Rural Doctors Network (NSW RDN) conducted a survey of all rural and remote female General Practitioners (GPs) and specialists in NSW. A matched cohort of male GPs was also surveyed to determine whether RDN's recruitment and retention strategies were meeting the needs of all rural and remote GPs in NSW. Differences observed in the effectiveness of the strategies for female and male GPs suggested that additional initiatives were needed to address issues raised by the female survey respondents. Subsequently the Rural Workforce Agencies (RWAs) in Victoria, Tasmania, Queensland and Western Australia (WA) surveyed their female GPs using the NSW RDN survey. The Rural Workforce Agency Victoria (RWAV) also surveyed its rural female specialists. In 2003, after the commencement of this study, the Rural Doctors Workforce Agency (RDWA) in South Australia (SA) used the NSW RDN instrument to survey its female GPs, and RDN surveyed the females in the Northern Territory (NT) on behalf of General Practice and Primary Health Care NT[1] (GPPHCNT).

On behalf of all Australian RWAs, the NSW RDN (as the budget holder) and RWAV obtained a grant from the Commonwealth Department of Health and Ageing (CDoHA) in 2002. The purpose was to develop a national database from the results of the states' surveys, and to propose strategies to increase the participation of females in the rural and remote medical workforce.

The current study is one of a number that are reviewing the future needs of the rural and remote GP workforce and that are looking at female specific priorities. Sustainable practice models (Wainer *et al*, 2001), and the Queensland Rural Medical Support Agency (QRMSA) and RWAV pilots of a female GP registrar mentoring program being undertaken on behalf of the Australian College of Rural and Remote Medicine (ACRRM, 2003a), are examples of projects that focus on particular aspects of rural practice for females. Most researchers have elicited the views and experiences of rural and remote female GPs and made recommendations on the basis of their findings (Tolhurst *et al*, 1997; RACGP, 2000; Tolhurst *et al*, 2000; McEwin, 2001; Tolhurst & Lippert, 2001; Wainer, 2001; Wainer *et al*, 2001; White & Fergusson, 2001; Greenwood & Cheers, 2002; Kilmartin *et al*, 2002; Roach, 2002; ACRRM, 2003b). This study incorporates the findings of the state and NT surveys, and earlier studies of female GP issues, and reviews current strategies in the light of those issues. Additional strategies as they relate to the survey findings are proposed.

The Australian Medical Workforce Advisory Committee (AMWAC) report on female participation in the medical workforce (AMWAC, 1996) and subsequent reports (AMWAC, 2000; Hirsch & Fredericks, 2001; ARRWAG, 2002) indicated that the female medical workforce was growing rapidly relative to the male medical workforce. The Australian female medical student population has been around 50% since the early 90's (AMWAC, 2002), but females comprised only 33% and 14% of the total GP and specialist workforce respectively in 2002 (ABS, 2002). There is increasing evidence that young male doctors want to work fewer hours than their predecessors did (AMWAC, 2002). This appears to be happening already with the workload carried by older GPs (50+) increasing by around 30% in the five years up to 2000 (Hirsch & Fredericks, 2001). To date there is no indication that female GPs will work longer hours than they do now (CDoHA, 2001) and this could result in serious workforce shortages in the future (McEwin, 2003). This potential work participation pattern has broader consequences in rural and remote Australia because of the increasing age of male GPs working in rural and remote locations who comprise more than 70% of that workforce (ARRWAG, 2002). The current rate of female recruitment to the rural and remote medical workforce is not sufficient to compensate for the expected exodus of rural and remote male GPs, and the workforce shortage will worsen unless the opportunity to work in those areas is made more attractive to females.

The outcomes of the national RWA surveys of rural and remote female GPs confirms the findings of recent major studies in this area (Tolhurst *et al*, 1997; Tolhurst *et al*, 2000; RACGP, 2000; Tolhurst & Lippert, 2001). This study is unique in having access to national data collected with the same survey instrument, for the development of a comprehensive national database. The de-identified data will be available to all the RWAs, and will constitute a critical resource in the development of their specific female workforce planning initiatives. This report is for distribution to a wider audience of stakeholders giving them the opportunity to consider the information obtained from this study when deciding how best to recruit female GPs through their organisations or in their regions.

1 In October 2003 the NT Remote Health Workforce Agency (NTRHWA) merged with the state based Divisional organisation, NT General Practice Divisions Inc to become GPPHCNT.

Chapter 2 – State of the Nation[2]

Introduction

At 30 November 2002 there were 3,855 GPs working in Rural, Remote and Metropolitan Area (RRMA) 4 to 7[3] areas of rural and remote Australia, and 28% of these were females. As Pope and Deeble (2003) have concluded:

"There are generally two types of doctors in rural/remote areas. The first is a group of older, largely male, resident GPs who work relatively long hours and who are likely to have been in rural, and to a lesser extent remote areas, for a long time. These doctors are likely to work in group practices in rural areas and in solo practices in remote areas, where group practice is not sustainable. They are more likely than other rural and remote doctors to regularly practice anaesthesia, obstetrics or surgery. The second is a group of transitory doctors who move in and out of rural and remote locations, often while training. These doctors are more likely to be younger and female, and a considerable proportion" are "overseas trained, ... They work fewer hours and are less likely to regularly practice anaesthesia, obstetrics or surgery but more likely to regularly practice emergency medicine and Aboriginal health." (Pope & Deeble, 2003 p.5)

Gender by State and NT

The percentage of female GPs working in RRMA areas 4 to 7 varies across the states and NT. South Australia has the lowest percentage of females of any state (24%) and the NT has the highest (43%).

Table 1 Female and male doctors in each State and the NT

State	Female		Male		Ratio
	n	%	n	%	female:male
NSW	284	26%	788	74%	1:2.7
VIC	223	28%	569	72%	1:2.5
QLD	264	30%	629	70%	1:2.4
WA	141	30%	324	70%	1:2.3
SA	93	24%	286	76%	1:3.1
TAS	47	30%	107	70%	1:2.3
NT	43	43%	57	57%	1:1.3
Total	**1095**	**28%**	**2760**	**72%**	**1:2.5**

(from Pope and Deeble, 2003, p.10)

Age

Female doctors in rural and remote areas are younger than male doctors, with 65% under the age of 45, compared with 43% of male doctors.

Table 2 Age in years of rural and remote doctors

	Under 35		35-44		45-54		55+	
	n	%	n	%	n	%	n	%
Female	227	23%	417	42%	277	28%	82	8%
Male	297	12%	806	31%	875	34%	586	23%
Rural 4	156	13%	382	33%	426	36%	213	18%
Rural 5	251	13%	657	34%	618	32%	391	21%
Remote 6	62	26%	91	39%	50	21%	33	14%
Remote 7	55	23%	93	39%	58	24%	31	13%
NSW	115	11%	312	30%	360	35%	246	24%
VIC	63	9%	225	33%	255	38%	130	19%
QLD	174	20%	317	37%	240	28%	126	15%
WA	91	20%	166	36%	131	28%	77	17%
SA	53	16%	128	40%	97	30%	45	14%
TAS	15	10%	46	31%	51	34%	37	25%
NT	13	19%	29	43%	18	27%	7	10%

(from Pope and Deeble, 2003, p.11)

2 Unless otherwise specified the comments and data contained in this chapter are from the Australian Rural and Remote Workforce Agencies Group (ARRWAG) report *Reality Bites* (Pope and Deeble, 2003).

3 The Rural, Remote, Metropolitan Areas (RRMA) Classification system was developed in Australia in 1994 for data analysis by zones. There are 2 metropolitan (RRMA 1& 2), 3 rural (RRMA 3, 4 & 5), and 2 remote (RRMA 6 & 7) zones based on population numbers and an index of remoteness (www.health.gov.au/ari/aria.htm).

Practice characteristics

The majority of GPs (80%) are resident GPs and these GPs are more likely to be male, older, in rural areas and in their current practice for over 5 years. The younger female GPs are more likely to be registrars or members of primary health care teams and are more likely to be working in remote areas and to have been in their current practice for less than five years.

Primary source of income

The primary source of income for rural and remote GPs is fee for service. The order in which the remaining rural and remote GPs derive their primary income is private practice salary, state salary with right of private practice, state salary without right of private practice, Aboriginal Community Controlled Health Organisation (ACCHO) salary, non-government salary, local government salary, and unspecified sources of income. More of the fee for service GPs are male, while more of those on private practice or ACCHO salaries are female.

Length of time in practice

The majority of the female doctors (65%) have been in their current practice less than 5 years, while the majority of the male doctors (53%) had been in their current practice over 5 years. The ratio of female to male doctors rises from 1:1.2 in those working at a practice for less than 1 year to 1:7.4 in those in a practice over 20 years.

Table 3 The ratio of female to male doctors by length of time in practice

Time in current practice	Ratio
	female:male
< 6 months	1:1.3
6-12 months	1:1.2
1-3 years	1:1.9
3-5 years	1:2.2
5-10 years	1:2.6
10-20 years	1:3.8
20 yrs +	1:7.4
Total	**1:2.5**

(from Pope and Deeble, 2003, p.16)

Practice type

Rural and remote GPs in Australia mostly work in group practices. The order in which they work in other practice types is, solo practice, hospitals, ACCHO, various other clinics, 'other', job share, solo co-located, virtual amalgamated, and joint practice with spouse. ACCHO practice is the only practice type where there are equivalent numbers of male and female doctors. In all others there are more males. There are the least female doctors in solo practice.

Table 4 Ratio of female to male doctors in the different practice types

Practice type	Ratio
	female:male
Solo	1:4.4
Group	1:2.3
Hospital	1:2.4
ACCHO	1:1
Total	**1:2.5**

(from Pope and Deeble, 2003, p.18)

Data from the RWA surveys of female GPs

The data obtained from the RWA MDS as summarised above, is consistent with the data obtained from the 666 survey forms that were returned by the female GPs who responded to the RWA surveys of their female GPs. Results of the data from the RWA surveys are contained in Chapter 4 (Results) and discussed in Chapter 5 (Discussion) of this report.

Chapter 3 Research Methodology

The NSW RDN survey tool was distributed to rural and remote female general practitioners in seven Australian states between 2000 and 2001 (NSW, Victoria, Queensland, WA and Tasmania) and in 2003 (SA and NT). Female GPs were identified from databases maintained and updated by the RWAs, and a total of 1127 surveys were sent to females who mostly worked in Rural, Remote and Metropolitan Area (RRMA) locations 3 to 7 (95%), and 5% from RRMA areas 1 and 2[4]. The survey return rate was 666 or 59%, with a range of 42% (Tasmania) to 78% (SA) (Table 5). The term 'rural' will be used throughout this report to encompass rural and remote unless specified otherwise.

Individual RWAs described the survey process in the discussion papers published in NSW, Queensland, Victoria and WA, and will not be reiterated here. Surveys were posted to 50 female GPs and registrars in Tasmania in 2001, and 21 GPs and one registrar responded. The RDWA in SA posted surveys and letters to 101 female GPs, locums and registrars from its database in May 2003. Two to three weeks after the first survey went out a follow up letter and survey was sent to female GPs who had not responded by the due date. Further phone contact was made with those who had not responded in the week leading up to the extended due date. Seventy-nine surveys were returned (78% response). Female GPs in the NT were surveyed by NSW RDN in April 2003. Surveys and letters were posted to 48 GPs, District Medical Officers (DMOs) and registrars following a phone call advising the recipients of the impending survey. Follow up surveys and letters were posted to females who had not responded by the due date, and a further phone call was made to ascertain that the survey had reached its destination. Additional surveys were posted to females who had not received them, had been missed off the first posting list, or were working away from their usual address during the survey period. Thirty-five surveys were returned by 26 GPs, five DMOs and four registrars (73% response).

Table 5 Dispatch and return of rural female GP surveys by State and NT

State	Number of surveys sent to female GPs	% survey return
South Australia	101	78%
Northern Territory	48	73%
New South Wales	302	67%
Queensland	236	53%
Victoria	271	52%
Western Australia	119	50%
Tasmania	50	42%

Survey format

The original NSW RDN survey format was largely retained. Individual RWAs made changes to elicit information about local workforce issues, for example the QRMSA survey included four additional questions about medical family support services in Queensland. Occasionally questions were reworded, for example the original NSW RDN question 'Are you working in a town without a hospital' was changed to 'Are you working in a town with a hospital' in some of the surveys. The responses to these questions were standardised for analysis. Appendix B contains a detailed explanation of the modifications made to accommodate changes to the survey questions, and definitions of the categories used for analysis.

Quantitative survey questions

Most of the survey questions (Appendix A) were designed to elicit demographic information about individual female GPs. These questions sought basic information about the females such as, age, number of children, number of hours worked, and number of years in rural practice. Other questions related to the females' lives and work, for example, having the main responsibility for childcare, whether they were raised in a rural area and satisfaction with their working hours.

4 The respondents worked across all RRMA areas including 33 females located in RRMA 1 and 2. The surveys were designed to obtain information about females working in RRMA 3 to 7 and the 33 females from RRMA 1 and 2 have been included because a substantial part of their practice is provided in rural and remote areas (e.g. Cessnock in NSW).

Open ended survey questions

The open-ended questions (Appendix A) covered other aspects of the female GP's life and work, for example, their reasons for choosing rural practice and the barriers that prevented them from working the hours they preferred. The females were asked if they were planning to leave rural practice or to change the nature of their work over the next five years, and their reasons for leaving or changing their present employment. The females were asked to identify their priorities for job satisfaction, training needs, major issues facing females in rural areas and the changes that they thought would improve recruitment and retention rates among rural female GPs. The females were given the option to nominate additional training needs to those proposed in the survey question, and their responses were divided into clinical and non-clinical topics. It was considered worthwhile to separate clinical and non-clinical training needs because the demand for clinical training may have created a bias in the response. The current interest of female GPs in leadership and other non-clinical work, and the training opportunities being provided by RWAs and other GP support organisations in some states, also made it useful to identify the national interest in those areas.

National responses to the questions about the major issues affecting female GPs in rural areas, and the changes needed to recruit and retain females in rural Australia were arranged under 12 broad headings (Table 6). The 12 headings were taken from the QRMSA Discussion Paper 'Female Medical Practitioners in Rural and Remote Queensland' (White & Fergusson, 2001) in which the authors placed individual female GP's responses to these questions into discrete groups to establish priorities. Examination of the responses from the female GPs in the other states and the NT showed that the major issues they identified and the changes they proposed corresponded to the same broad headings used in the QRMSA Discussion Paper (White & Fergusson, 2001).

Where the female GPs identified more than one major issue or suggested more than one change all the answers were included in the database. Details of the females' responses under the individual headings are contained in Chapter 4 (Results). These headings provided a reference point for discussion of the themes and ideas raised by the female GPs throughout this report. The suitability of any new strategies proposed in this study was considered in relation to these 12 headings (Chapter 7).

Table 6 Major issues and changes identified by rural female GPs in order of priority

Major Issues	Changes
Personal and professional isolation	Flexible work opportunities
Childcare	Support Networks
Workforce demands	Childcare
Role conflict	Financial incentives
Flexible work arrangements	Flexible access to Training/CME
Partner's needs	Family issues
Other issues	Attitudes to female medical practitioners
Children's services and education	Locum provision and funding
Flexible training opportunities	Rural exposure and attitude
Attitudes to female GPs	Children's education needs
Safety and security	Other issues
Locum services	Safety

Each of the headings in Table 6 was individually coded for statistical analysis in the software package, SPSS 11.5 (formerly known as Statistical Package for Social Sciences), to assist in the establishment of national priorities.

Frequency tables, histograms and graphs of the data provide summaries and visual representation of the trends, and are contained in Chapter 4 (Results).

Chapter 4 Results

The section headings below represent the domains covered by the survey questions as follows:

A. DEMOGRAPHIC DATA

(e.g. age, marital status, Division of General Practice (DGP) membership, number of children),

B. LIFE AND WORK MATTERS OF RURAL FEMALE GPS

(e.g. reason for choosing rural practice, satisfaction with working hours, plans to leave or change practice), and

C. RECRUITMENT AND RETENTION OF FEMALES IN THE RURAL WORKFORCE

(e.g. job satisfaction ratings, training preferences, major issues, changes needed to recruit and retain females).

A. DEMOGRAPHIC DATA

RRMA

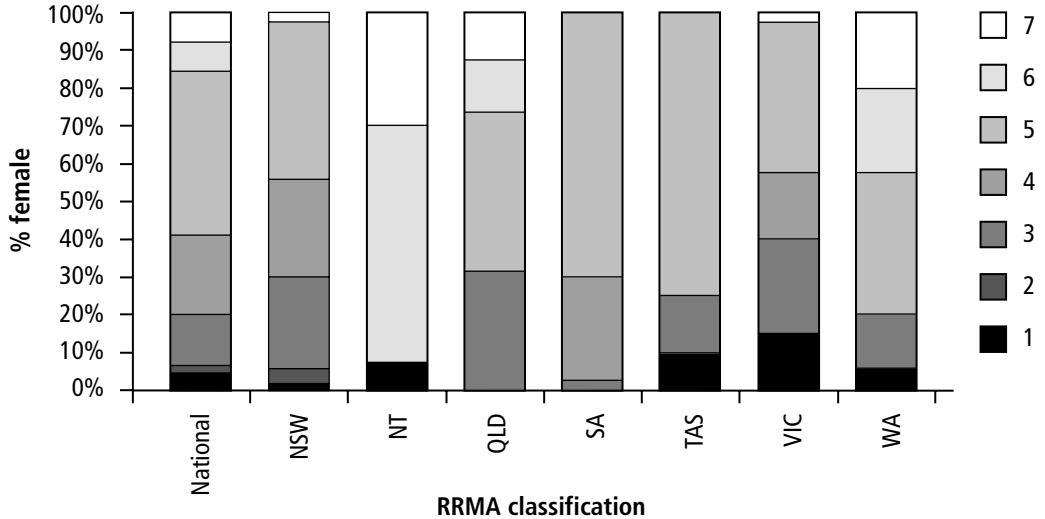
The majority of female GPs worked in RRMA 3 to 5 (78%), and 93% worked in RRMA 3 to 7 (Table 7). RRMA classifications were not available for 2% of the respondents.

Table 7 RRMA classification for female GPs

RRMA	1	2	3	4	5	6	7
%	4	1	13	23	42	8	7

The greatest proportion of females in RRMA 3 worked in NSW and Victoria. Queensland, NSW and SA had comparable proportions of females working in RRMA 4 and the greatest proportion of females in SA (71%) and Tasmania (75%) worked in RRMA 5. Two thirds of the females in NT worked in RRMA 6 and the remainder in RRMA 7, while 80% of females in WA worked in RRMA 5 to 7 (Figure 1).

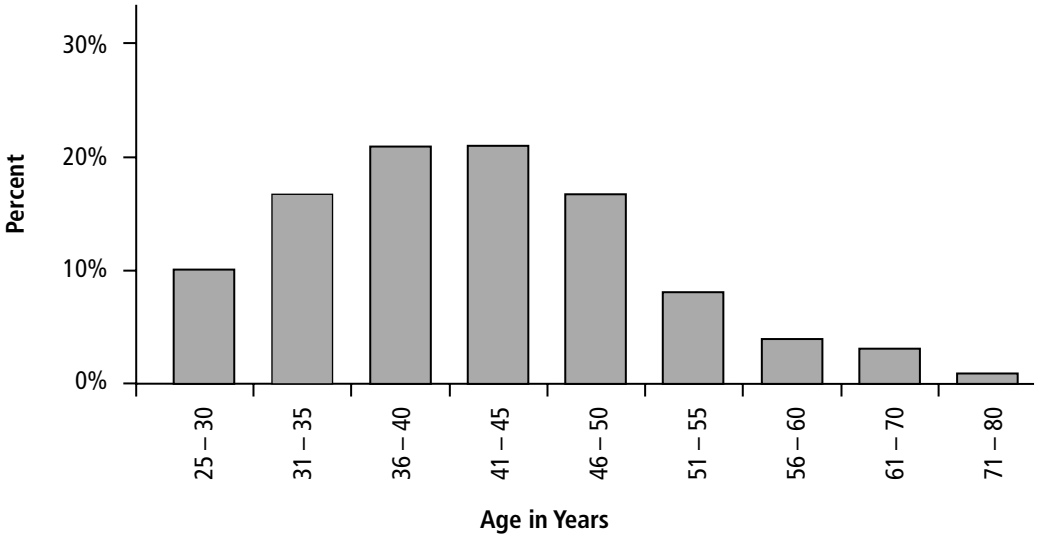
Figure 1 RRMA location of female GPs by State and NT



Age

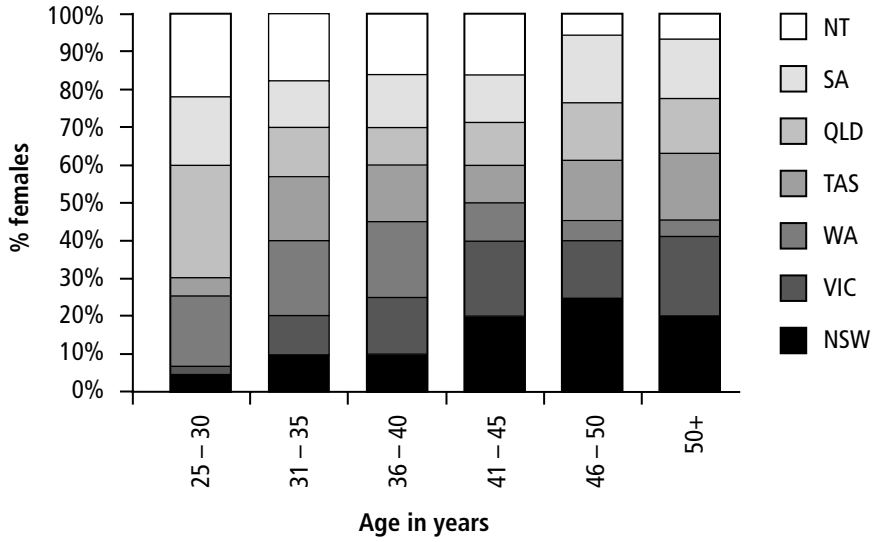
The age distribution of the females is presented in five and 10-year intervals (Figure 2). The females' ages ranged from 25 to 76, with 83% aged between 30 and 50, and 94% being 55 years or younger.

Figure 2 Age distribution of female GPs



There was some variability in age of female GPs across the states and NT. Females aged between 25 and 40 years were more likely to be working in Queensland (59%), NT (67%), SA (55%) and WA (75%), while females over 40 years were more likely to be found working in NSW (70%) and Victoria (59%). In Tasmania 50% of the female GPs were aged between 25 and 40 years (Figure 3).

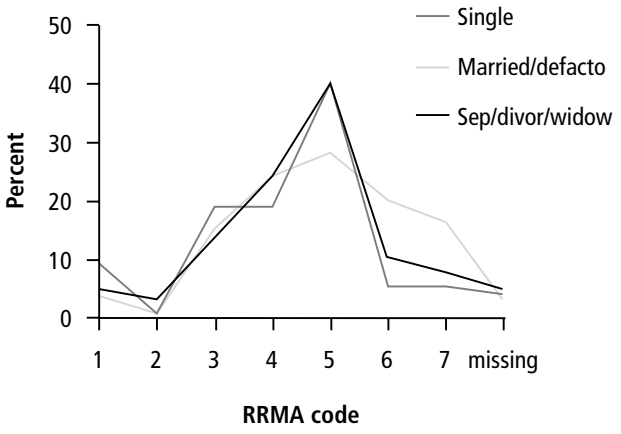
Figure 3 Ages of female GPs by State and NT



Relationship status

Most of the females were in relationships (83%), 10% were single and 7% were separated, widowed or divorced. Single females were more likely to be working in RRMA 6 and 7, while females in a relationship, or those who were divorced, separated or widowed were most often located in RRMA 5 (Figure 4).

Figure 4 Relationship status by RRMA location



Children

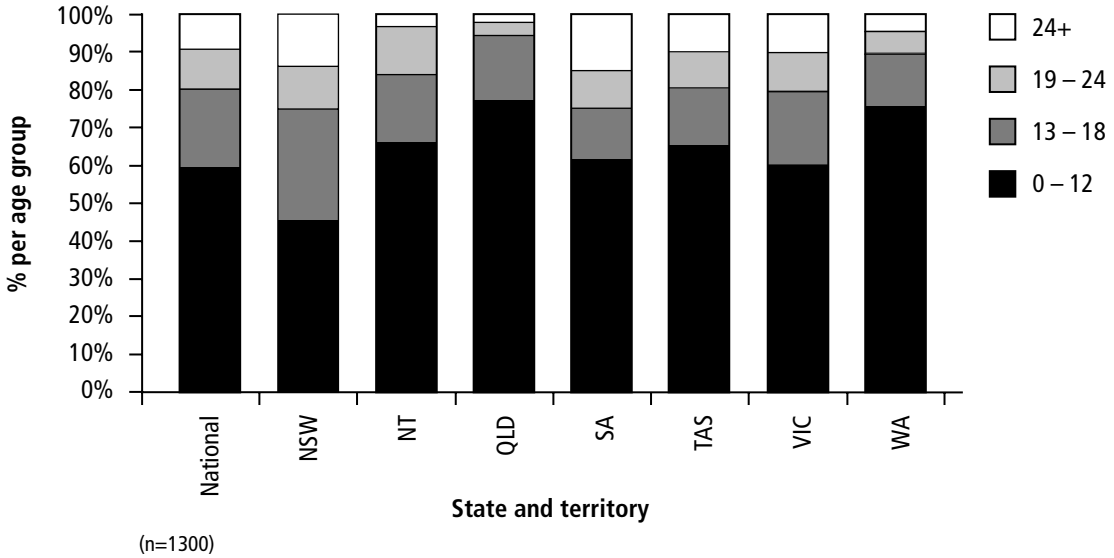
Three quarters (76%) of the females had children. Most commonly they had two (41%) or three (31%) children, and 98% of those with children had between one and four (Table 8).

Table 8 Numbers of children

Number of children	1	2	3	4	> 4
% females	14	41	31	12	2

Twenty four years is taken as an arbitrary cut off point for children to cease being dependent on their parents, as by then they have had time to complete a tertiary qualification. By this definition, the majority of female GPs had dependent children. Given the younger age profile of the females in Queensland, WA, SA and NT (Figure 3), it is hardly surprising that they have proportionally more children in the youngest age group than the other states (Figure 5).

Figure 5 Proportion of children in each age group by State and NT



(n=1300)

Membership of Division of General Practice

Nationally 90% of the female GPs were members of a Division of General Practice (DGP). All the states equalled or exceeded the national figure except Queensland and the NT (Table 9).

Table 9 Proportion of females who are members of a Division of General Practice

State or NT	Member of Division of GP (%)	Non-member of Division of GP (%)
National (n=652)	90	10
NSW	94	6
NT	80	20
Queensland	81	19
SA	90	10
Tasmania	90	10
Victoria	94	6
WA	90	10

Year of graduation

The year of graduation ranged from 1947 to 2001. Two thirds of the female GPs graduated between 1976 and 1990. Nearly one quarter graduated after 1990 (Table 11).

Table 11 Year of Graduation

Year	Frequency	Percent	Cumulative Percent
1947-1970	49	7.4	7.4
1971-1975	55	8.3	15.8
1976-1980	143	21.5	37.5
1981-1985	130	19.5	57.2
1986-1990	130	19.5	76.9
1991-1995	97	14.6	91.7
1996-2001	55	8.3	100.0

(n = 659, 9 missing)

College affiliation

Nationally 40% of the females belonged to the RACGP with a range of 60% (Tasmania) to 34% (Victoria). National membership of ACRRM was 10% and ranged from 0% (Tasmania) to 17% (NT and SA). Nationally 30% of female GPs were not affiliated with any college and this figure was lower in the NT, Queensland, SA, WA and Tasmania, and higher in Victoria and NSW. The range of non-affiliated females was 18% (SA) to 35% (Victoria). In WA the number of females holding membership of both colleges (RACGP and ACRRM) was 22% and markedly higher than the national figure of 15% (Table 10).

Table 10 College affiliation of respondents from each state and the NT (%)

College	RACGP	ACRRM	Both	Other	One/both & other	None
National	40	10	15	2	3	30
NSW	39	10	14	2	1	34
NT	49	17	11	0	0	23
Queensland	40	12	17	2	0	29
SA	44	17	19	1	1	18
Tasmania	60	0	5	5	10	20
Victoria	34	9	11	6	5	35
WA	37	5	22	0	8	28

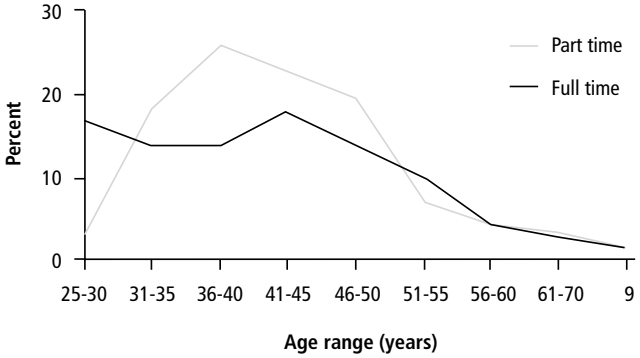
History of previous metropolitan practice and previous rural practice

Sixty one per cent of respondents who answered the questions about their previous practice history (n = 662) had worked in a metropolitan practice prior to entering rural practice, and 52% had worked in a rural practice before working in their present practice.

Hours worked

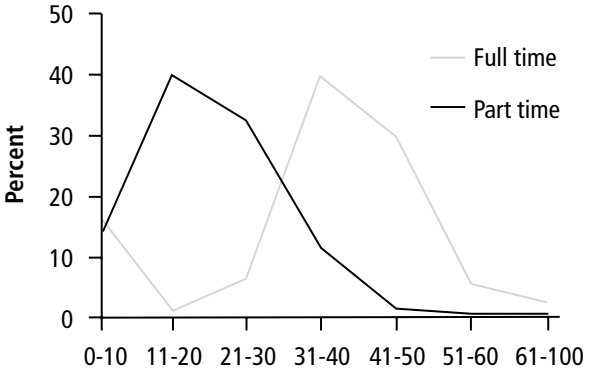
Fifty two per cent of the females worked part time and were most likely to do so between the ages of 31 and 50 (Figure 6). Forty two per cent said they worked part time for family reasons. (See Appendix B for a definition of part time).

Figure 6 Age ranges of part time and full time female GPs



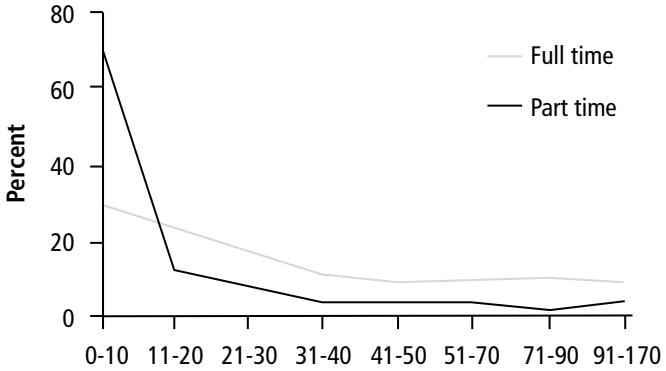
Thirty-five clinical hours per week was the crossover point between part time and full time practice (Figure 7). Part time females mostly worked less than 35 clinical hours per week. There was some overlap between 30 and 50 hours because some part time females worked more than 35 clinical hours per week and some full time females worked less. A small proportion (14%) of full time females worked up to 10 clinical hours per week. These females worked primarily in other medical roles such as medical adviser to GP organisations or in training roles, but wanted to maintain their skills by retaining some of their clinical work.

Figure 7 Number of clinical hours for part time and full time female GPs



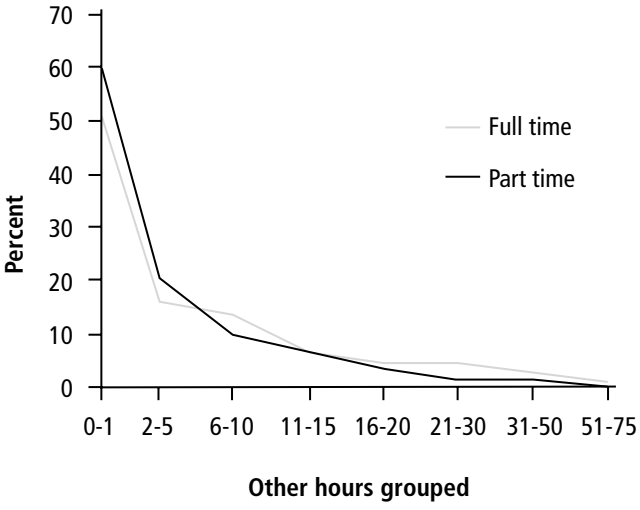
Weekly on call hours for all females peaked between 0 and 10. Part time females were two to three times as likely as full time females to be doing between 0 and 10 on call hours per week. Full time females were four to five times as likely to be doing more than 20 on call hours per week. The proportion of full time females working between 40 and 168 on call hours per week remained constant while the proportion of part time females declined (Figure 8).

Figure 8 Number of on call hours for part time and full time female GPs



The majority of females working 'other' hours worked less than five hours a week and there was very little difference between part time and full time females. 'Other' work included practice administration and management, teaching, other clinical work including palliative and aged care, sexual assault clinics, youth and Aboriginal health, medical journalism, board and committee membership and Divisional work (Figure 9).

Figure 9 Number of other hours for part time and full time female GPs



B. LIFE AND WORK

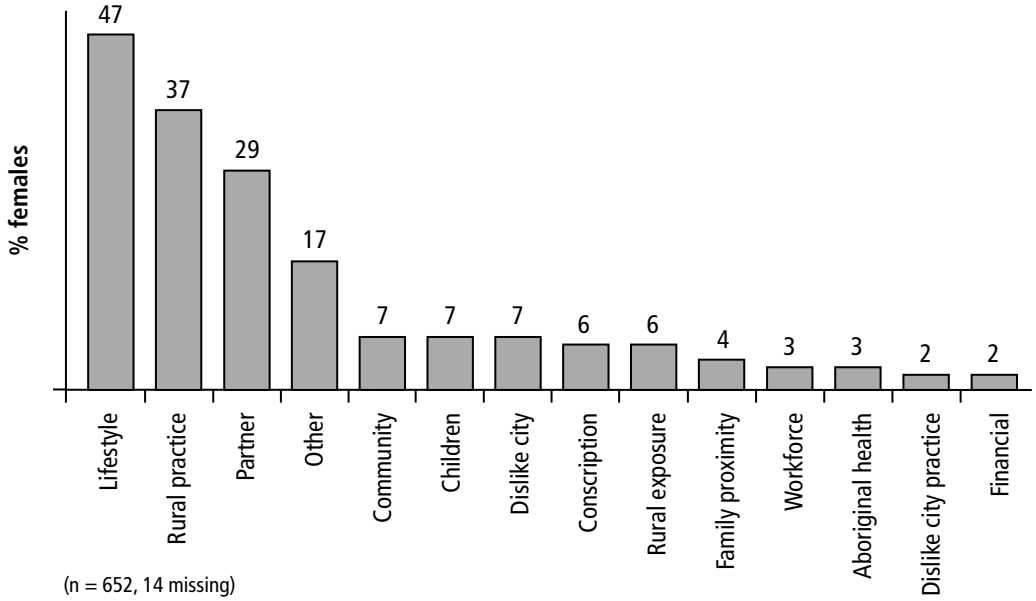
Raised in a rural area and rural origin

Of the 37% of females raised in a rural area, 75% were raised in rural Australia and 25% in rural areas outside Australia.

Reasons for choosing rural practice

Professionally, 37% of the females considered rural practice as a major attraction because it offered variety, continuity of care, autonomy and the opportunity to practice procedural medicine. Other professional incentives were contract or work requirements (6%), workforce shortages and the needs of rural communities (3%), an interest in indigenous health (3%) and a dislike of city practice (2%). Lifestyle was the main personal reason cited by 47% of the females, followed by their partner's choice (29%). The females considered that raising their children in a rural area was a good and safe option (7%), disliked city living (7%) and liked having links with the community (7%). A small number had a previously enjoyable exposure to rural life (6%), some wanted to be close to their extended families (4%), and a small number were motivated by money (2%). 'Other' reasons (17%) included international travel and general comments about the nice people, work opportunities, work experience, fresh air, being near friends and compatibility with the environment (Figure 10).

Figure 10 Primary reasons for female GPs to choose rural practice



The top three reasons female GPs gave for choosing rural practice were lifestyle, to work as a rural GP and their partner's choice. The females' responses were collapsed under major headings in the state RWA reports and may have been interpreted slightly differently in each report. This would account for any variability in the figures quoted between state RWA publications. The females in WA were twice as likely as those in the eastern states (slightly less in Tasmania) to work in rural areas for the opportunity of experiencing rural medical practice. Females in the NT were 50% more likely on average to choose rural practice for the lifestyle than all the other states except Tasmania. In NSW the females were almost 50% more likely than the national figure to be in rural practice because they had followed their partners (Table 12).

Table 12 The top three reasons respondents gave for choosing rural practice by State and NT

Reasons %

State	Lifestyle	Rural practice	Partner
National	47	37	29
NSW	43	30	42
Victoria	50	30	36
Queensland	41	31	23
WA	52	62	22
SA	51	49	16
NT	69	54	9
Tasmania	60	40	15

Main responsibility for childcare

Females carried the main responsibility for caring for their children (44%) or shared the responsibility with their partners (22%). A small proportion (5%) said they were not the main carer but did not nominate an alternative carer, and 28% had no dependent children or no children.

The figures for being the responsible child carer and for sharing the care were quite different in each state and the NT. Females in Victoria and NSW were most likely to be the main carer of their children, and those in Tasmania and the NT were most likely to share the care with their partners. The numbers of NA (no children or children didn't require care) partly explain the differences (Table 13). Where the rows do not add up to 100% the respondents answered the question in the negative but did not nominate the carer and are not included in the table.

Table 13 Female GPs having main responsibility for childcare by State and NT

State	Yes (%)	Shared (%)	NA (%)
VIC	56	21	14
NSW	67	10	19
TAS	40	40	20
SA	33	29	34
QLD	24	27	37
WA	20	30	47
NT	9	34	57

Partners' occupations

The most common occupation of the female GP partner was a medical practitioner (25%) (Table 14).

Table 14 Partners' occupations

Occupation	Frequency	Percent
Medical practitioner	169	25.4
Technical or specialty worker	87	13.1
Legal, IT, business professional	44	6.6
Community worker, health professional, religious	35	5.3
Farmer	34	5.1
Retired, student, unemployed	34	5.1
Teacher, academic	34	5.1
Office, administration	18	2.7
Other	7	1.1
NA (single, separated, divorced or widowed females)	102	15.3
Missing (in a partnership but did not specify partner's occupation)	102	15.3
Total	**666**	**100.0**

Satisfaction with hours worked

Fifty four per cent of the females were satisfied with their current working hours while 41% would have preferred to work fewer hours and 4% would have liked to work more hours.

Barriers to working preferred hours

Of the 45% of females, who were not satisfied with their working hours, 70% were working full time (Table 15).

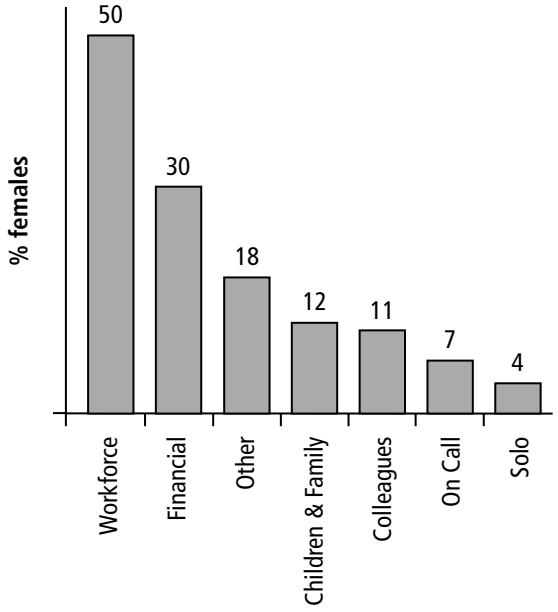
Table 15 Satisfaction with working hours by full time/part time status

Satisfaction with working hours	Part time or full time	
	Part time (%)	Full time (%)
Prefer fewer hours	25	75
Prefer more hours	88	12
Satisfied with current hours	71	29

(n = 658, 8 missing)

Of the females who were not satisfied with their hours, 50% were prevented from working fewer hours because of patient demand and workforce shortages, while 30% were inhibited by financial considerations. The females cited children and family responsibilities (12%) as a reason for preferring fewer hours or not being able to take on more hours, while pressure from colleagues (11%) and on call requirements (7%) prevented them from working less hours. Solo practitioners usually had little choice in the hours they worked (4%). The 18% who nominated 'other' barriers cited responsibility, loyalty, guilt, distance issues, commitment to other projects, limited work availability, self health issues, administrative overload, contract constraints, practice structure and their own work styles as reasons for not being able to work their preferred hours (Figure 11).

Figure 11 Barriers to female GPs working their preferred hours



Position in practice

The females were most commonly employed on a salary in the practice (29%) or were practice associates (26%) (Table 16). 'Other' positions were recorded by the females as independent contractor, assistant on percentage, sessional, public health physician, registrar, non-government organisation (NGO) employee, and Royal Flying Doctor Service (RFDS).

Table 16 Proportion of female GPs in a range of practice positions

Position	Frequency	Percent
Salaried	195	29.3
Associate	174	26.1
Other	107	16.1
Partner	100	15.0
Solo	57	8.6
Locum	27	4.1
Missing	6	0.9
Total	**666**	**100.0**

The proportion of female GPs in rural (RRMA 3 to 5) and remote (RRMA 6 to 7) areas is 5:1. The chance of a female GP being a partner or associate in a practice is much more likely in a rural area (Table 17).

Table 17 Ratio of females by practice location and position

Distribution of female GPs by location and position	Ratio	
	Rural	Remote
Female GPs	5	1
Salaried	3	1
Associate	18	1
Other	4	1
Partner	12	1
Solo	4	1
Locum	4	1

Working in town with a hospital and doing hospital work

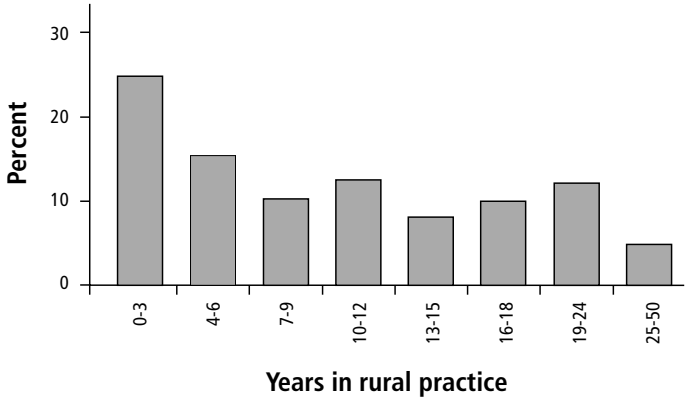
Eighty seven per cent of the females worked in towns with a hospital and 71 % of them did hospital work. A small number of females did hospital work but were not working in towns with a hospital. They are included with the 71% who did hospital work.

C. RECRUITMENT AND RETENTION

Total years in rural practice

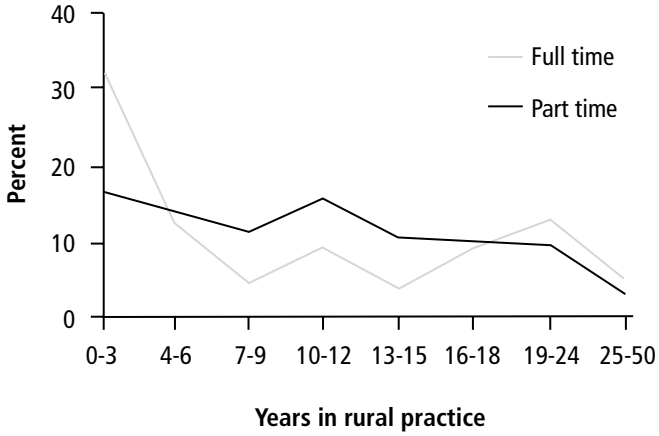
Fifty percent of female GPs who responded to this question (n = 658) had been in rural practice for less than 10 years and 24% of these were there for less than four years. At the other end of the scale 26% of the females had spent more than 15 years in rural practice. The most common time period the females had spent in rural practice was up to three years (Figure 12).

Figure 12 Total years spent in rural practice by female GPs



Full time female GPs dominated the rural female GP workforce at two points on the continuum of years spent in rural practice, namely up to three years, and again beyond 19 years. During the intervening years female GPs were more likely to work part time in rural practice (Figure 13). (See Appendix B for a definition of part time.)

Figure 13 Years in rural practice for part time and full time female GPs



Nearly two thirds of the females in NSW and Victoria, and less than a quarter of the females in WA and NT spent more than 10 years in rural practice (Table 18). The NT and WA also had the highest proportion of females in rural practice for less than five years.

Table 18 Retention rates of female GPs by state and NT

Region	% in rural practice less than 10 years	% in rural practice less than 5 years
National females	50	40
National all GPs (MDS 11/02)	68	52
NSW	38	26
Vic	38	28
Qld	60	51
SA	58	51
WA	78	64
NT	77	65
Tas	45	35

Planning to leave rural practice or change the nature of work in next five years

The females were asked if they were planning to leave rural practice or change the nature of their work in the next five years. Their responses were as follows:

- Planning to leave – 20%
- Undecided about leaving – 23 %
- Planning to change the nature of their work – 25%
- Undecided about changing – 25%

Personal reasons prevailed in the decision for females to leave rural practice or to be undecided about leaving (Table 19). Personal reasons included retirement, children's secondary education needs, moving to be closer to family, partner's employment and to have more children. The 'Other' reasons largely described the females' intended action to leave or make a change and did not provide a reason, for example 'prefer no on call work' or 'may relocate, may do fewer sessions and more non-medical work'.

Figure 14 shows considerable variation in retention rates between the states.

Figure 14 Retention rates of female GPs by State and NT

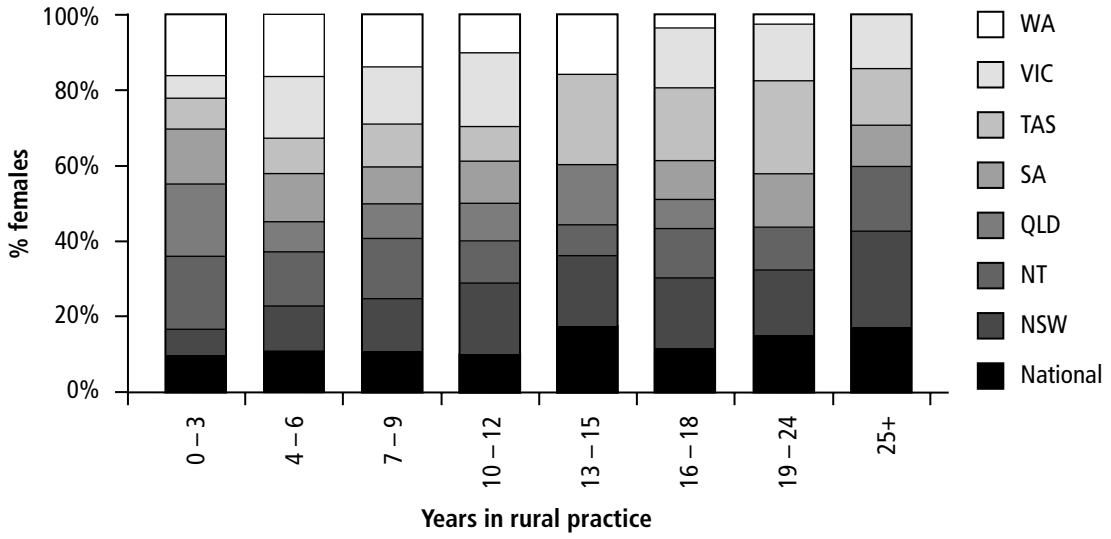


Table 19 Female GPs leaving practice or changing nature of work

Leaving (%)	Undecided about leaving (%)
Personal – 54	Personal – 57
Professional – 41	Professional – 37
Other – 5	Other – 6
Changing (%)	**Undecided about changing (%)**
Personal – 40	Personal – 43
Professional – 50	Professional – 46
Other – 10	Other – 10

The majority of females who had no plans to leave their current practice in the next five years worked in RRMA 3 to 5, and those who were most likely to be planning to leave or were undecided were in RRMA 6 and 7 (Table 20).

Table 20 Female GPs planning to leave their current practice in the next five years by RRMA location

RRMA	Planning to leave current rural practice		
	No (%)	Yes (%)	Undecided (%)
3 to 5	60	17	22
6 to 7	23	43	34

(n = 641, 25 missing)

When planning to change the nature of their work or being undecided, the females more often cited professional reasons (Table 19). Professional reasons included, specialising in other clinical areas, increasing the companion therapy component of their work (e.g. acupuncture), changing focus from general practice (e.g. hospital work, medical education), discontinuing obstetrics, increasing their procedural work and embarking on a different career.

The majority of females who were not planning to change the nature of their current practice worked in RRMA 3 to 5, and the majority of those who were planning a change worked in RRMA 6 and 7 (Table 21). The females' responses to their being undecided about changing the nature of their practice in the next five years were similar across RRMA locations.

Table 21 Female GPs planning to change the nature of their current practice in the next five years by RRMA location

RRMA	Planning to change nature of current practice		
	No (%)	Yes (%)	Undecided (%)
3 to 5	47	24	25
6 to 7	39	35	25

(n = 624, 42 missing)

The remaining four questions in the survey sought information from the females about the following matters:

- job satisfaction,
- preferred training topics,
- major issues affecting females in the rural medical workforce, and
- changes they felt would improve the recruitment and retention rate among females.

The females were asked to prioritise their job satisfaction issues and training needs from a list that reflected the requirements identified in a pilot study on the educational and support needs of rural female GPs by Tolhurst *et al* (1997).

They were also asked in open-ended questions to identify the major issues affecting females, and the changes that would improve the recruitment and retention of females, from their own experiences as rural GPs.

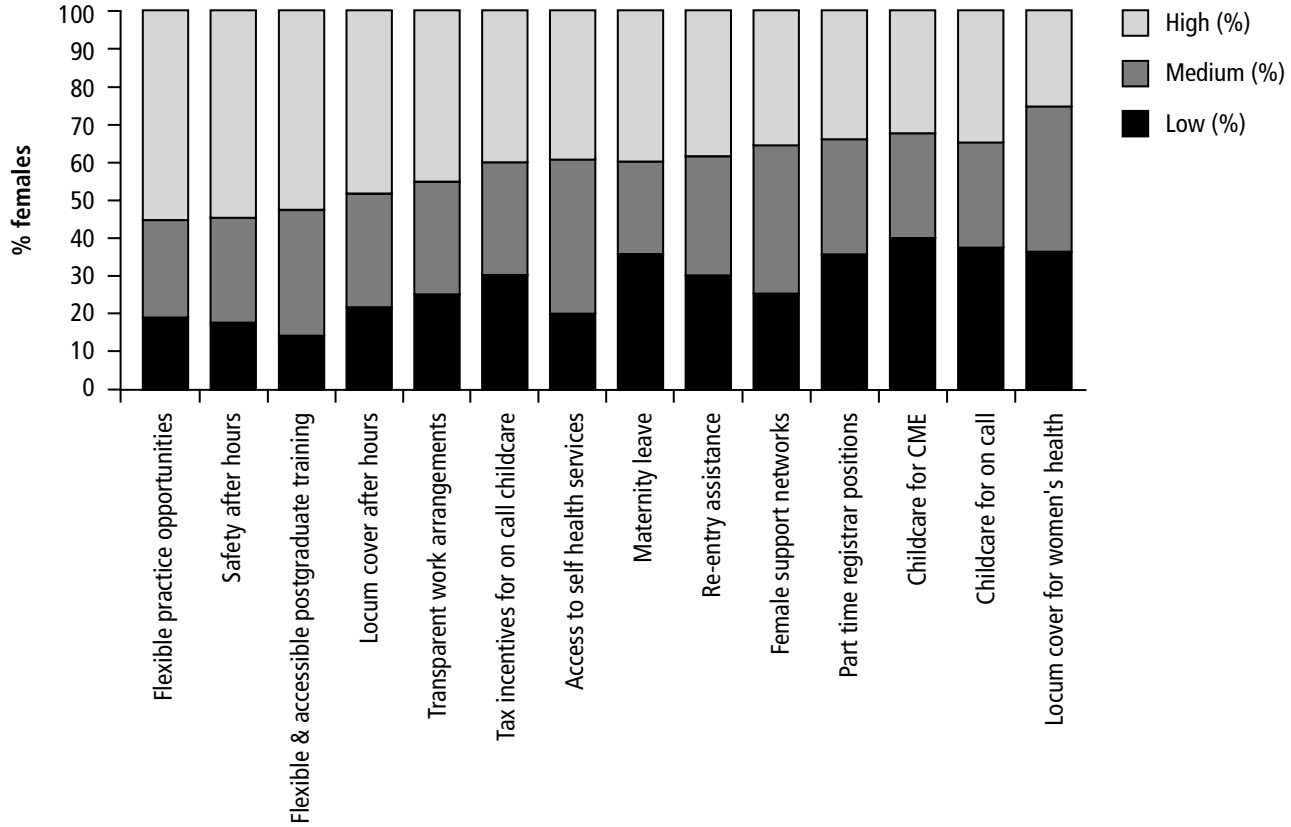
Job Satisfaction

The females' priorities for job satisfaction are shown in Figure 15. The rankings were based on a scale of one to seven where one is of least importance and seven is most important. The rankings of high, medium and low were calculated as follows:

- HIGH – the combined rankings of six and seven (from the scale 1 – 7),
- MEDIUM – the combined rankings of three, four and five (from the scale 1- 7), and
- LOW – the combined rankings of one and two (from the scale 1 – 7).

Flexible practice opportunities, safety after hours, and flexible and accessible postgraduate training were the three 'high' priority areas for job satisfaction, each receiving a high priority ranking from more than 50% of the respondents. Although access to self-health services and female support networks were ranked further down on the 'high' priority list they ranked more highly as 'medium' priority issues at 39% and 41% respectively, than any other issue, which placed them among the top six areas for job satisfaction (Figure 15).

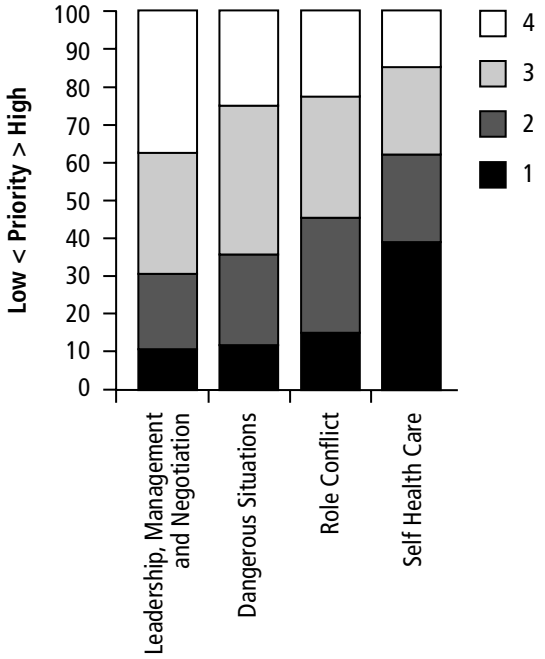
Figure 15 Priority given to 14 job satisfaction options by female GPs



Training

The results of the females' priorities for training are shown in Figure 16. The rankings were based on a scale of one to four where one is of least importance and four is most important. The females were provided with four non-clinical Continuing Medical Education (CME) options and ranked training in leadership, management and negotiation (31%) above methods of dealing with threatening, difficult and dangerous situations (20%), dealing with role conflict (18%) and training in self health care (11%). Nominations of 'Other' training options were invited and were grouped for analysis as either clinical or non-clinical. Examples are provided below but are not an exhaustive list of the females' choices. One quarter of the females identified more clinical training as a need including procedural skills, mental health, women's health, sexual health, obstetrics and gynaecology, oncology, public health, paediatrics, aged care, Aboriginal health, chronic disease management, rural emergency medicine and grief counselling. Non-clinical training needs were identified by 10% of the females and included practice and business management, planning for retirement, computer skills, financial planning, superannuation, assertiveness, contract negotiation and presentation skills.

Figure 16 Priority given to four non-clinical CME options by female GPs



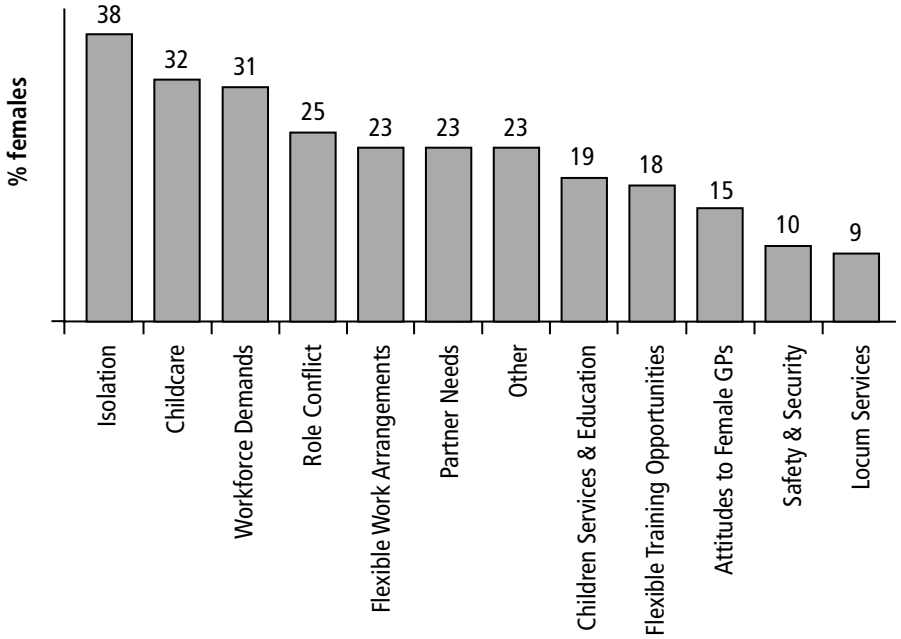
Major Issues

(Survey question: What do you see as the major issues affecting female medical practitioners working in rural areas?)

Professional and personal isolation was the major issue for the female GPs, followed by childcare and workforce demands (Figure 17 and Table 23). Locum services and safety and security received the lowest ranking relative to the other major issues (Figure 17). The 'Other' major issue category included negotiation of equitable conditions, lack of practice and salary guidelines, appropriate remuneration, time management, own and family health, travel and associated costs, lack of experience, skill maintenance, lack of career options, cooperation between community and medical groups, bureaucratic imposts, and training and mentoring opportunities.

The use of an open-ended rather than a closed question format, sometimes resulted in responses that attributed the same issue with a contrasting priority. For example, safety and security received a low ranking as a major issue (an open-ended question) (Figure 17), but was ranked highly under the job satisfaction (closed question) (Figure 15) and training priorities (closed question) (Figure 16).

Figure 17 Priority given to the major issues affecting rural female GPs



As isolation and access to childcare could be more problematic in some states or the NT, the priority given to these two issues by the females in different states and the NT is shown in Table 22. Isolation was an issue for more than 50% of the respondents in two states and the NT, and childcare was nominated as an issue by more than 50% of the females in the NT.

Table 22 Priority given by female GPs to the top two major issues by State and NT

State	Number of respondents	Isolation (%)	Childcare (%)
National	618	38	32
NT	31	58	55
WA	54	52	43
VIC	138	51	39
NSW	181	41	38
SA	71	32	30
QLD	126	28	21
TAS	18	28	28

Specific responses to the question about major issues affecting female GPs are shown in Table 23 to ensure that the females' intended meanings are captured. The 'Other' issues heading is not mutually exclusive of the rest and is included because some of the items crossed over into other categories, for example 'ability to practice time management' relates to flexibility in the workplace, attitudes of colleagues and self health care.

Table 23 Major issues affecting female GPs in rural areas (from White & Fergusson, 2001)

Major issues	Female GP responses
Personal and professional isolation	Personal – loneliness and isolation Professional – peer and service support Emotional and personal support Lack of anonymity, privacy and space Shortage of role models
Childcare	Access Cost Travel to and distance from service For after hours and on call Subsidies
Workforce demands	Amount of after hours and on call Overall GP shortage Patient demand and expectations Long hours Additional hospital and paper work Job satisfaction Confidence for emergency and on call after re-entry Succession planning difficulties
Role conflict	Difficult to balance home and work On call intrusion on home life
Flexible work arrangements	Flexible hours to accommodate family needs Maternity leave
Partner's needs	Employment availability Role as GP partner Social and professional support available Personal and professional isolation
Other issues	Remuneration for rural practice Negotiation for equitable conditions Equitable salary as if private practitioner Ability to practice time management Long consultations for female health and counselling not adequately remunerated Own health care Distance to and from practice Remuneration for travel and time costs Bureaucratic imposts Indemnity insurance for obstetrics Rural experience during training Career options Practice and salary guidelines Cooperation between community and medical groups Reverse urban/rural disparity Currency or loss of skills

Major issues	Female GP responses
Children's services and education	Quality secondary education Health needs Recreational facilities
Flexible training opportunities	More CME Access to CME and other training events Locally available Childcare for attendance Travel subsidies Part-time registrar training
Attitudes to female GPs	Acknowledgement and support of colleagues and organisations of the multiple roles of many female GPs and their need for flexibility to perform those roles adequately Role conflict is often different for females than males and requires different strategies
Safety and security	Safety and security especially for after hours and on call
Locum services	Availability of locums Availability of female locums Locum relief for family emergencies, and holiday and other standard leave

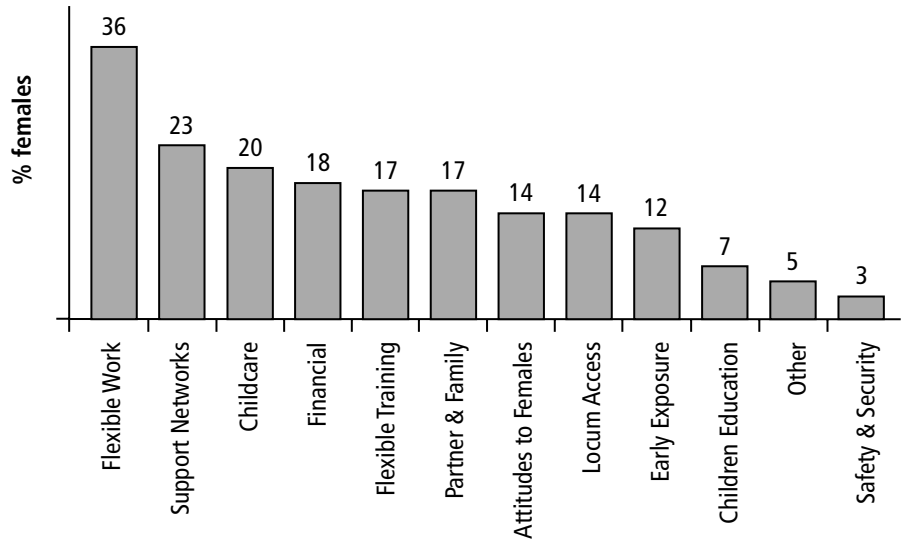
Changes suggested to increase recruitment and retention

(Survey question: What changes do you feel are needed in order to recruit and retain female medical practitioners in rural and remote (name of state or territory)?)

The female GPs identified a range of changes that they felt would increase the recruitment and retention of females in the rural workforce. Seventy nine per cent of the females responded to this question.

Figures 17 and 18 show that the females consistently identified workforce matters, isolation and lack of networks, and childcare among their top priority major issues and areas requiring change. Access to flexible work arrangements (36%) was viewed by the females as the most important incentive to luring female GPs into the rural medical workforce and to overcoming the practice demands that were serious inhibitors to their retention. The development of support networks (23%) was the second highest priority for change, and was seen as a way of overcoming the isolation that rural females experienced. The third priority for change was increased access to, and affordability of, childcare (20%). The females also identified various financial aspects (18%) associated with rural practice that they thought required change to make it more affordable and equitable, and to be more attractive to new recruits. Preparation for rural life and practice through early exposure (12%) during training was considered to be an area that also needed more attention if females GPs were to be retained in rural areas.

Figure 18 Changes needed to increase recruitment and retention of rural female GPs



Specific responses to the question about the changes needed to increase the recruitment and retention of rural female GPs are shown in Table 24 to ensure that the females' intended meanings are captured.

Table 24 Changes recommended by female GPs to increase recruitment and retention (from White & Fergusson, 2001)

Changes	Female GP responses
Flexible work opportunities	Part time opportunities Clear understanding of work contract and conditions Less on call and no after hours house calls Redistribution of 'on call' from 'practice' to 'town' – better practice grants Maternity leave in private practice Job sharing Rostered leave – change patient expectations Provider number issues Childcare for after hours Flexibility and awareness of employment options More practitioners
Support Networks	Reduce social and professional isolation Supportive family Supportive colleagues for self and family Supportive DGP and Colleges for self and family Access to professional contacts via phone, video etc
Childcare	Regular and after hours – flexible Available for CME and other events Access – distance Tax deduction Subsidies

Changes	Female GP responses
Financial incentives	Increase Medicare rebate for rural items Redistribute 'on call' grants from practice to town Salary incentives with rural loading to attract doctors Remuneration to help cover costs Medicare rebates reflecting long consultations for counseling and multiple health issues
Flexible access to Training/CME	Increase amount available Access – locally provided Part time and full time Childcare Part time registrar positions Re-entry training and updating Locum cover to attend
Family issues	Partner's satisfaction with job and social life Community support for partner's employment and training Appropriate local services – shops, schools, social Good and sufficient housing Support female GPs with partner issues
Attitudes to female medical practitioners	Male domination of rural GP culture needs to change Part time is real and valuable Non-procedural work is valid On call is a genuine problem with young children Role conflict acknowledged by males Doctors and community lose 'super doc' image Female GPs as role models Promote benefits of female GP to communities
Locum provision and funding	Access to cover Females available Available for all occasions – CME, maternity leave, holidays Increased funding for more locums
Rural exposure and attitude	During medical training and from beginning Encourage rural origin females to enter medicine Promote positive experience of rural life Good preparation for rural life and practice Change attitudes of students and society to rural life Compulsory graduate rural placement Mentor with female who has adapted successfully
Children's education needs	Better opportunities Access Remuneration assistance
Other issues	Practice management training Preparation for rural practice prior to entry Adequate after hours triage Increased support referrals Relocation to accommodate secondary education needs Retain government services in rural areas
Safety	Ensure workplace and after hours safety

Chapter 5 Discussion

Introduction

Rural workforce planning projection data indicate that significant future workforce shortages are likely to occur in rural and remote areas over the next decade due in part to the expected retirement of older rural male GPs (Hirsch & Fredericks, 2001; McEwin, 2003). In view of these predictions, workforce planners are increasingly focused on addressing inequities in health service delivery in rural and remote Australia (CDoHA, 2001). With increasing numbers of females participating in the Australian medical workforce (Hirsch & Fredericks, 2001; ARRWAG, 2002), a review of current recruitment and retention strategies for new rural GP recruits is due. With this in mind it is critical that policy makers and planners be aware of the personal and professional needs of females when considering the focus of future GP support programs.

The RWA survey responses demonstrated that rural practice is still an attractive long term work environment for females, with 50% of the female GPs who responded working in rural or remote locations for 10 years or more. Females most commonly cited personal reasons (rural lifestyle) for entering rural practice, as they did when asked why they were planning to leave rural practice within the next five years. Attraction to rural practice as a profession was the second most common reason the females gave for choosing rural medicine, and those who had decided to change the nature of their current practice within five years cited professional reasons. Understanding the allure of rural practice for females, and the impediments to them continuing in their chosen field of medicine will assist in the development and implementation of strategies to attract females to rural general practice and to support their participation over time.

The following discussion of key findings from the national surveys attempts to identify the links between the demographic data and the females' responses to the open-ended survey questions, and to demonstrate the value of these links in the formulation of recruitment and retention strategies.

Demographic data

The RRMA location of a female GP's workplace was found to impact on a range of issues identified from the survey responses. As a consequence, the varied distribution of female GPs across RRMA locations and between the states and NT may necessitate a range of different approaches to local issues. Single female GPs were more likely than those in a relationship to practice in remote areas. The likelihood of females becoming practice partners or associates was greatly reduced in remote practice, which could impact on their commitment to remain there. This is reinforced by the findings that females in remote practice were more likely than their counterparts in rural locations to be leaving their current practice or planning to change the nature of their work in the next five years. Implementing strategies that target females in remote practice, by addressing job opportunities and career development, could result in higher levels of female recruitment, and increased retention rates in those areas.

Most of the female GPs had children, and the majority of the children were still dependent on their parents. Nationally, females were twice as likely to be the main carers of their children than to share the responsibility with their partners. Females in Victoria were two to three times as likely, and in NSW more than six times as likely, to be the main carers of their children than to share the care with a partner. In contrast the females in NT, WA and Queensland more often shared the care with their partners, with the females in NT four times as likely to share the care than to do it alone. The higher frequency of females having the main responsibility for childcare seen in Victoria and NSW could be due to different generational values being held by the older females in those two states.

Childcare and secondary schooling were both identified by the females as issues that required attention if they were to meet the competing demands of their jobs and families. The females have identified a clear link between the reality that most female GPs have dependent children, and the inadequacy of services to help them raise their children and work in rural Australia. As half of the females were aged less than 40 years the issues around the children of female GPs will not be resolved without the introduction of changes to the way females are supported in the rural medical workforce.

Findings from open ended survey questions

Female GPs have identified a range of changes that they regard as important in increasing the recruitment and retention of females in the rural medical workforce. The following discussion focuses on changes suggested by the females, and their relevance to the survey findings about barriers to their preferred working hours, indicators for job satisfaction, training priorities and major issues for female GPs in rural locations.

Flexible work opportunities

The highest priority area for change was the ability to have a work situation with enough flexibility to accommodate the multiple roles undertaken by the females as a doctor, mother, wife and woman in the community, and was nominated by 36% of the female GPs who responded to the survey. Specific aspects of a flexible workplace included:

- the ability to work part time,
- flexibility around on call commitments within the practice,
- sharing after hours work with other practices or hospital doctors,
- relief or locum cover to take time off for holidays,
- cover to respond to emergency family needs such as the illness of a child or regular family needs such as school holidays,
- job sharing opportunities, and
- access to and affordability of female locums.

Among the 52% of females who worked part time, 75% were satisfied with their hours, and two thirds of the full time females would have preferred to work fewer hours. Nearly three quarters of the part time females undertook up to 10 on call hours per week compared with less than 30% of their full time colleagues. Some females described the strong pressure to do on call work even though it was incompatible with their family responsibilities. The high proportion of part time females doing on call is possibly a reflection of their response to pressure from colleagues to participate equally in all aspects of the practice. The structure of the practice and the females' position in it also inhibited their ability to determine their hours. This sometimes came about because there was an expectation from male colleagues that the females would carry a high workload despite having the main responsibility for their families' care and welfare. At other times females had failed to negotiate a suitable work contract that allowed them some flexibility to fulfil their responsibilities to the family and the practice. Many recognised their lack of skill in this area and this is discussed under flexible training options.

Workforce issues were the main barriers to the females being able to work their preferred hours and were nominated by 50% of respondents. The two most common workforce issues cited by the females were:

- patient demand, and
- shortage of doctors to carry the patient load.

Additional reasons included:

- little or no access to locum cover,
- insufficient female doctors,
- limited procedural opportunities,
- finding a compatible new practice partner, and
- the increasing administrative load.

A further 7% of the females nominated on call demand separately from workforce issues as a barrier to working their preferred hours. The on call requirement is clearly a difficult area for female GPs and one that requires creative thinking to resolve. Where the respondent was the only female GP in the area it was difficult to reduce the female patient load which is often a large component of the female GP's work. Administrative tasks were nominated by many females as an extra burden and 76% spent up to five hours per week doing 'other' work which included organising referrals for patients, confirming test results, ringing patients, and doing practice management tasks.

When rating 14 options for their importance to job satisfaction, nearly 60% of the females put flexible practice opportunities at the top of the priority list. The contribution of transparent work arrangements to job satisfaction was another of the options in this survey question and nearly 50% of the females rated it as highly important on their priority list.

When the female GPs were asked to nominate the major issues affecting females in rural practice, access to flexible work arrangements was their fifth highest priority. Among the other major issues the females cited were workforce demands (31%) and role conflict (25%), which could be partly or wholly resolved by providing a flexible work situation.

The theme of flexibility as it relates to the workplace appears consistently in the females' responses to the open-ended survey questions. The nature of their work limits the females' ability to be flexible themselves and the additional responsibility of family care compounds the problem. From their own experiences they identified it as the most important area for change when looking to increase the recruitment and retention of rural female GPs. Three of the top five major issues nominated by the females, workforce demands, role conflict and flexible work arrangements, had flexibility as the common theme.

New female and male recruits to the rural medical workforce are already indicating that they want to work fewer hours. Male medical students, like their female counterparts who are already in rural practice, are not interested in a career that requires them to be on call every day of the year, and twenty four hours a day. The introduction of flexibility into the workplace or enhancements to existing flexible workplace options, are matters for serious consideration by all stakeholders. Individual GPs, and organisations concerned with training, industrial and workforce matters should be concerned, because inflexible work and training options are likely to impact on more then 50% of the rural workforce in the future.

Support networks

The females have placed support networks as their second highest priority area for change that could help to increase the recruitment and retention of rural female GPs. Personal and professional isolation were often identified in tandem and support networks for the personal and professional aspects of the females' lives are considered here. Some of the changes suggested by the female GPs included:

- development of networks to overcome social and professional isolation,
- support for the family,
- support for themselves from Divisions, Colleges and colleagues,
- access to other professionals through telephone or video-conferencing,
- access to primary care teams for referrals and some procedures,
- help with domestic chores,
- a supportive local hospital,
- access to female mentors for new GPs and trainees, and
- emergency and specialist backup.

The females considered that specific female support networks were important for job satisfaction and ranked it among their top six priorities. Among the major issues nominated by the female GPs, isolation was given the highest ranking of 38% nationally. Females in the NT cited isolation more often (58%) than females in the states, although it was also a high priority issue for the females in WA (52%) and Victoria (51%). The following themes were identified as features of isolation:

- personal and professional isolation,
- lack of emotional support,
- lack of support from peers and other service providers,
- lack of privacy and anonymity in the community,
- lack of role models, and
- inadequate family services.

The data showed that nationally, 30% of the females were not affiliated with any college, thus denying their access to the support that those professional organisations are best equipped to provide. The colleges have a major role in the provision of support services to medical practitioners, including networking and training opportunities. Isolation and access to flexible training were both identified by the female GPs as major issues (38% and 18% respectively), and as areas requiring change to improve recruitment and retention rates (23% and 17% respectively). It may be possible to help overcome the isolation that some females experience by increasing their affiliation with the colleges, although some may need encouragement to understand how this will increase their personal and professional networks, and to appreciate the benefits.

One possible reason for the observed level of non-membership is that the very issues of isolation and work pressure nominated by the females are the issues preventing them from maintaining appropriate professional networks. When Strasser *et al* (1997) conducted the National Rural General Practice Study they determined the involvement of rural and remote GPs in seven key training and support programs, and observed that females were less aware of the programs than males. Their evidence suggested that females might be expected to be equally involved if their awareness of the programs was increased.

Conversely most of the females have aligned themselves with their Division of General Practice and could benefit from the support services they provide.

Childcare

Childcare was identified by 20% of the females who responded to the question about change. They considered it to be the third most important area requiring attention for improving the recruitment and retention rates of rural female GPs, and specifically its:

- flexibility for after hours cover,
- affordability as a tax deduction, and
- availability during CME and other events.

As a barrier to working the hours they preferred, the females did not rate childcare as highly as the workforce and financial issues. In their assessment of childcare as a job satisfaction priority the females rated it more highly as a tax deduction than they did for its availability for after hours work and during CME events. However the females did see it as the second most important of the major issues facing rural female GPs.

The female GPs in NT and WA were younger than the other states and rated childcare as a high priority issue (55% and 43% respectively). The females in Queensland and SA also had a younger female GP workforce but did not rate childcare as highly (21% and 30% respectively) as the NT and WA. While the females in NSW and Victoria were older, they still rated childcare as a high priority issue (38% and 39% respectively).

Having limited access to childcare during normal working hours meant that females were committed to part time practice unless they were in a position to have the child with them during working hours. This was not an option expressed by many females in the surveys. There was also a perception from the community that the medical family was well paid and could afford childcare if they needed it. The female GPs rated tax deductible childcare costs highly under job satisfaction, and it was a major issue preventing females from attending CME events. The absence of after-hours childcare impacted on the females' ability to fully participate in the activities of the practice and this resulted in a loss of income and poor perception of their contribution by male colleagues. Although it may have been possible to take a child when they were on call, the females rarely suggested this as an option because it resulted in disruption to the family, feelings of guilt and role conflict, and distraction from the job. Some females felt that taking a child to work was seen as an indication that they were not managing their family obligations adequately.

Financial incentives

There was a small proportion of females (2%) who stated that they chose rural practice for financial reasons but they were clearly a minority group. Thirty percent of the females who were not satisfied with their work hours were unable to change them because of financial considerations. In terms of job satisfaction, the females rated a tax rebate for childcare as a medium to high priority. When considering the major issues female GPs rated childcare as their second highest priority and that included the affordability of the service as well as its availability. Although locum services were the females' lowest priority of all the major issues, they specified funding for locum cover as part of that issue. The females rated financial incentives as their fourth highest priority area requiring change to improve the recruitment and retention rates of female GPs. This came about largely because many of the areas requiring change had a financial component, thus pushing financial incentives up among the higher-ranking issues. The females specifically nominated the following financial issues:

- increased remuneration through Medicare rebates for rural items,
- redistribution of practice grants for on call from 'practice' to 'town',
- creation of salary incentives to attract more females,
- financial incentives to cover additional rural costs, and
- remuneration for long consultations routinely performed by female GPs.

As discussed above, the commitment of female GPs to part time work largely occurred during the period when they were most likely to be having and rearing their children. This was confirmed by analysis of the survey data that showed full time numbers exceeding part time on either side of the child-rearing period, that is, below the age of 31 and over the age of 50. The ability of females to earn an equitable salary was limited during this period of their lives as a result of part time work. Yet in some ways they had overheads that could exceed their ability to earn. Thirty per cent of the females had a financial burden that did not allow them to reduce their work hours even though there were other life matters making demands on their time. Some of the females were the only wage earner and others were partners or in solo practice with the accompanying high overheads. Among those who wanted to work part time there was the burden of medical indemnity that soaked up a large proportion of their part time earnings. An additional expense for females who sent their children

to boarding school was the cost of secondary or tertiary education and travel for the children to return to the family during school holidays. The costs of childcare for females to attend CME and other events, and for after hours and on call work, was also a disincentive to reducing their work hours.

Although female GPs are known to be twice as likely to have long consultations as male GPs (AMWAC, 1996), females are still not remunerated for the way they practice medicine, particularly in rural areas. The lack of remuneration has several untoward effects. The females reported that they were considered not to be contributing equally to the practice income because they completed fewer consultations in a session than their male colleagues. For some this led to poor relationships with practice colleagues, reduced access to practice incentive funding and a diminished income overall. Where some females wanted to actively increase their income and work hours this was sometimes limited by the size of the patient base and inadequate space in the practice rooms.

Flexible access to training

The female GPs rated flexible and accessible postgraduate training highly when asked to nominate the indicators for job satisfaction in order of importance to them. As a major issue, flexible training opportunities received a medium to low rating, but was in the high range among the changes needed to increase the recruitment and retention of rural female GPs. The females specifically identified the following changes with regard to meeting the training needs of female GPs:

- availability of good local training,
- practical procedures,
- better training opportunities – part time and full time,
- childcare available at CME activities,
- locum cover to attend, and
- re-training/updating for re-entry after an absence to raise a family.

There were a number of matters that impacted on the females' training needs. In addition to the CME requirements for vocational registration, rural general practice posed additional challenges to the female GPs' knowledge base. General practice in rural areas required the females to have a suite of skills that were not always used in urban practice where patients could readily be referred to other service providers as needed. Some of the females had not anticipated the range and variety of skills they would need in rural practice and 23% of those who responded to the survey question about their training needs said they would like more clinical training. Some of the areas they specified were:

- accident and emergency, anaesthetics
- counseling, sexual assault, domestic violence, mental health
- paediatrics
- women's health
- musculo-skeletal medicine
- obstetrics, gynaecology, breast problems
- hormone therapy
- aged care
- dermatology
- sexually transmitted diseases, sexual health

Longer consultations routinely conducted by female GPs involved the treatment of numerous health issues at each encounter and often included counseling for mental health problems. In addition to the emotional burden the females were concerned that they were not appropriately trained to treat patients with mental health problems.

After lifestyle, the two main reasons female GPs gave for choosing rural practice were the opportunity to practice medicine in a rural area, and to follow their partners' choice of location. The 29% of female GPs who were in rural practice to be with their partners were not always adequately skilled to practice medicine in that environment. Many of the females also stated that they would like to have had the opportunity to experience rural life and practice during their undergraduate and graduate training years and be prepared to meet the challenges they now faced.

In addition to the circumstances associated with their move to a rural or remote area, the females cited some specific factors that required them to refresh their skills. Those who had taken time out from work to have and rear their children needed re-entry training to boost their confidence and upgrade their skills and knowledge. Working part time for an extended period meant that some females were out of touch with new practices and treatments, and they wanted to receive training to keep them abreast of medical innovations. Another group of female GPs described themselves as 'pap smear' specialists who were relegated to routine tasks in the practice because of their part time status. They were concerned about losing their skills and wanted training to maintain their knowledge of contemporary medicine and practices.

Attitudes to female GPs

A proportion of female GPs (11%) identified the expectations of their colleagues as a barrier to reducing their work hours to accommodate their family responsibilities. Some of the females were in equal partnerships, and others were in areas with only a small number of GPs, and were expected to 'pull their weight'. Many of the females in these situations also felt bound to support their GP colleagues and applied pressure on themselves to participate equally. An additional expectation of the female GPs to be available as needed came from their patients, and again the females felt duty bound to support them. The most contentious area was sharing the on call load. The fact that the females identified it separately as a barrier to their preferred work hours was discussed under flexible work opportunities. The on call commitment was the most difficult aspect for the females to resolve because of their own childcare responsibilities and because of the deterioration in relationships that often accompanied their refusal to participate at the level their colleagues felt was fair. Salaried females numbered nearly 30% and were most likely to need to negotiate their work contracts. Contract negotiation included the level of on call commitment and was an area where the females did not feel strong enough to state their requirements. This was reflected in the fact that they gave the highest priority for their training options to leadership, management and negotiation, and 10% requested additional non-clinical training to include assertiveness and contract negotiation.

When it came to the major issues affecting female GPs they did not rate the attitudes of their colleagues and the community very highly. Similarly when it came to suggesting changes to improve recruitment and retention, the matter of colleagues' and communities' attitude to females was in the medium to low priority range. In spite of the low rating given to this matter the females identified some quite specific areas for change around:

- male dominated culture and discrimination,
- opportunity and acceptance by full time male GPs that part time and no on call is legitimate medicine,
- acceptance of the validity of non-procedural work,
- attitude change around the 'super docs' image,
- acceptance of role conflicts and family life,
- promotion of rural females as role models,
- positive promotion of the benefits of female GPs to communities and practices,
- community attitudes to female GPs being full time mothers,
- practice attitudes to low income farmers,
- change in attitudes of teaching and city hospital personnel,
- more clear advice as to female GP's rights,
- preventing burnout by changing old practices, and
- improving communication through patient records to allow continuity of care by more than one doctor.

Female GPs recognised that the relationships with their colleagues and the perception of the community, in particular their patients, were affected by the level of their participation in the workforce. Some females responded by complying with those expectations, and became tired and in danger of reaching 'burn out'. Others maintained their hours as much as possible to minimise the degree of role conflict that they experienced. In fact 14% of the female GPs considered that some change in attitude towards females was needed to increase their recruitment and retention. The matter of changing attitudes towards female doctors, and awareness of the legitimacy of the multiple roles of females, is increasingly coming to the fore in the literature, and is being reflected in some of the activities of medical organisations. There is more focus on female doctors' issues, especially in the areas of policy and decision making, role modeling and increasing the profile of females generally.

Access to locum cover

In this study 4% of the female GPs identified themselves as locums and they were located fairly evenly across the states, except in Tasmania and NT where none were identified. These state differences may be due to the operation of diverse locum and remuneration arrangements in individual states and the NT.

Female GPs identified the availability and affordability of locum cover for family holidays, CME and additional training, maternity leave and personal emergencies as an area requiring change to increase the recruitment and retention of rural female GPs. There was a perception by the females that locum cover needed to be more heavily subsidised to make it more accessible.

It is possible that the importance of locum cover to female GPs could have been related to their reason for using the service. For example, obtaining locum cover for the after hours component of their work was identified by the females as a high priority for job satisfaction. They were at risk of not pulling their weight and of adding to the burden of their practice colleagues by not fulfilling their after hours commitment. Whereas locum cover for women's health matters was rated separately under job satisfaction and received the lowest priority rating from the females. In this case they were the ones to bear the burden of the workload for women's health,

as their female patients were prepared to wait for their return rather than see the male GP. Similarly, as a major issue, locum cover came in last, and was a medium to low priority area under changes needed to increase recruitment and retention of females. There could be a number of explanations for the low emphasis on locum cover overall, such as the cost, the individual practice policy around use of locum services, previous experience with the availability of locums, particularly females, and awareness of the service.

Rural exposure and attitude of students and community to rural practice

Twelve percent of the female GPs who suggested changes to increase recruitment and retention believed that previous exposure to rural practice would be a great advantage to females coming into rural practice. A small proportion of the females (6%) identified their previous exposure to rural life and practice as one of their reasons for entering rural practice. A greater number (7%) reported a preference to raise their children in a rural area. Good rural experiences for students and GP trainees could induce them to stay on, or return at a later life stage with their families. Among the number of females (37%) who were raised in a rural area, 47% chose rural practice for the lifestyle it offered them and their families. The females rated rural exposure at the low end of their priorities for changes to increase recruitment and retention rates but nominated some specific actions:

- exposure to rural practice from the first year in training,
- promote rural practice as a positive experience,
- encourage rural origin females to enter medicine,
- change society and students' attitudes to county life,
- make graduates do 6 – 12 months in a rural placement,
- encourage females to work in rural areas before their children reach school age,
- introduce a better recruitment system for students wanting to enter rural practice, e.g. lower entry criteria to medical studies, and
- ensure adequate training for rural emergency medicine and general practice.

In the following section (Chapter 6) the rural incentive programs for undergraduate students are discussed under 'Rural exposure'. Some of the areas requiring change that were identified by the females in this study may not have been available when they were training. They are now being addressed at the undergraduate level through the Rural Health Clubs, Rural Students Entry Scheme, Rural Clinical Schools, rural undergraduate placements and bonded scholarships. There has also been some measurable increase in the recruitment of rural students to medicine. Female medical student recruitment has increased overall and females currently comprise more than 50% of the medical student body.

Safety and security

The survey questions for job satisfaction and training opportunities included safety and security and the females were asked to rate the importance of this issue. In both cases the females gave safety their second highest rating. However, when the females were asked to nominate the major issues for females and the changes that were needed to increase recruitment and retention, they put safety and security at the bottom of the priority list. The females did not detail their considerations around safety and security and mostly noted that changes should ensure the safety of female GPs in the workplace and during after hours and on call.

It is not clear why this matter was such a low priority for females in the surveys. The strategies coming out of the report by Tolhurst *et al* (1997) provided some commonsense approaches to safety in the workplace. There is anecdotal confirmation that when females do recognise their situation as being potentially dangerous they take particular precautions to ensure their own safety, such as conducting the consultation at the local hospital or taking someone with them to do a house call at night. The issue of providing safety guidelines for practices is ongoing, and the RACGP accreditation standard 5.1 designates the provision of appropriate facilities that promote health, safety and comfort for all parties. A description of the premises provides some detail about how to ensure that the practice is secure, especially after hours. Female GPs are potentially at risk from within and outside the practice, and there have been anecdotal reports of medical families being threatened at home by intruders looking for drugs when the GP is away at the surgery.

Chapter 6 Review of Current Recruitment and Retention Strategies for Rural and Remote GPs

Introduction

A number of articles report on the issues affecting recruitment and retention of rural GPs and on current measures that seek to address these issues (AMWAC, 1996.7, 1996.8, 1998.4, 2000.2; Veitch *et al*, 1999; Hays *et al*, 1997; Kamien, 1998; Strasser *et al*, 1997, 1999, 2000; Wainer *et al*, 2001; Wilkinson *et al*, 2001; McDonald *et al*, 2002; Mitka, 2001; Kilmartin *et al*, 2002; Humphreys *et al*, 2002a). While rural female medical practitioners have clearly identified the issues that concern them (McEwin, 2001; Wainer, 2001; Roach, 2002; White & Fergusson, 2001; Tolhurst & Lippert, 2001), only a small number of the current strategies to increase recruitment and retention focus on the issues for rural female GPs. Although some of the obstacles to successful recruitment and retention are similar for females and males (McEwin, 2001), most of the existing large-scale recruitment and retention initiatives do not have a specific gender focus and are not able to address the particular work requirements of female GPs. These initiatives include the high school and undergraduate initiatives, Commonwealth Rural and Remote General Practice Program, Rural Retention Program, Rural Medical Family Support Scheme, Rural Locum Relief Program, the State Government Area of Need Programs and programs to support overseas trained doctors.

The following discussion of current strategies relates to GP workforce initiatives that are closely aligned to the 12 broad groupings that the female GPs thought were important for recruitment and retention. An attempt is made to maintain the link between the females' suggestions for improving recruitment and retention, and the way that existing strategies address some of these issues. The recruitment and retention strategies have been identified from a variety of sources including the research literature, the websites of GP support and other organisations, or are a result of discussions with stakeholders. The latter include the Australian RWAs, ARRWAG, DGP, ACRRM Women in Rural Practice (WIRP), RACGP National Rural Health Faculty, Institute of Sustainable Futures (ISF), the Rural Doctors Association of Australia (RDAA), the Rural Doctors Association (RDA) NSW, individual female GPs, researchers looking at workforce issues, representatives of the CDoHA and State Health Departments.

Methodology

A search of Australian and overseas literature, and a Medline search using the key words 'rural' 'female' 'medical' 'practitioner', were conducted for the period following the Commonwealth and State government strategies implemented after the inception of the General Practice Rural Incentives Program[5] (GPRIP) in 1991, and its subsequent funding in the Federal Budget of 1992.

Among more than 70 papers reviewed for this study, 12 of those published in Australia between 1996 and 2002 looked at personal and professional issues for rural female GPs specifically, and for female medical practitioners in general (AMWAC, 1996; Tolhurst *et al*, 1997; RACGP, 2000; Tolhurst *et al*, 2000; Tolhurst & Lippert, 2001; McEwin, 2001; Wainer, 2001; Wainer *et al*, 2001; Roach, 2002; Greenwood & Cheers, 2002; Kilmartin *et al*, 2002; White & Fergusson, 2001). The 12 publications contained a total of 296 recommendations and the frequency of individual issues as they appeared in these publications is shown in Table 25.

Table 25 Recommendations for recruitment and retention of rural and remote female GPs and their frequency in 12 publications

Recommendation	Frequency in 12 publications
Access to flexible training	10
Flexible work opportunities	8
Support networks	8
Rural exposure	8
Family issues	8
Childcare	7
Safety/security	6
Own health care	6
Leadership training & opportunity	5
Attitudes to female GPs	5
Other issues	5
Locum access	5
Financial incentives	4
Representation in policy making	3
TOTAL	**88**

5 The Commonwealth General Practice Rural Incentives Program (GPRIP) was replaced by the Rural and Remote General Practice Program (RRGPP) in 1998 with funding provided to establish RWAs in all the states and Northern Territory. Responsibility for programs under the RRGPP was assigned to the RWAs.

Data supporting the recommendations in these 12 publications were collected by various means including surveys, questionnaires, regular data collection exercises (AMWAC and the Australian Institute of Health and Welfare [AIHW]), conference proceedings, in-depth interviews, focus groups and literature reviews. Notwithstanding the different collection methods, the frequency data above show how closely the findings from the rural female GP surveys in this study align with results of previous research. The high priority issues for rural female GPs are flexibility in work and training opportunities, personal and professional support networks, the benefits of early exposure to rural life and practice, family needs and childcare, peer and community attitudes, access to female locums, and safety and security in the workplace.

Much of the research published over the last few decades that addresses recruitment and retention of the rural GP workforce has focused on issues that are relevant to male GPs and has not identified the specific problems that female GPs experience. As a result there has recently been a burgeoning of publications reporting on studies conducted with the express purpose of ascertaining the interests and needs of the rural female GP workforce. Females have now had a number of opportunities to express their views about workforce matters and their messages are generally consistent. This study aims to consolidate the available data to provide a logical basis for the formulation of some achievable and sustainable strategies to address these recurring themes. These are discussed further in Chapter 7.

GP recruitment and retention strategies

In a review of rural GP recruitment and retention strategies, McDonald *et al* (2002) examined published evaluations of current recruitment and retention strategies and their relative success. The authors developed an 'Evidence-Based Rating' (EBR) scale and applied it to the published evaluations of Australian and overseas strategies for recruitment and retention of rural GPs (Table 26).

Table 26 Recruitment and retention strategies reviewed by McDonald *et al* (2002)

Strategy	Australia	Overseas
Funded Scholarships (with obligations)	Various large and small-scale programs	Various large and small-scale programs
Preferred Student Admission (Rural Background)	Various large and small-scale programs	Several long-term locally based programs
Rural Placements (Medical Students)	Various large and small-scale programs	Various large and small-scale programs
Overseas Trained Doctors	Various programs	Various programs
Continuing Medical Education	Various locally based programs	Various programs
Locum Relief	Various locally based programs – no evaluation of recruitment or retention	Various programs
Financial Incentives to GPs	Various large and small-scale programs	Various large and small-scale programs
Recruitment Officer/Case Manager	Specific program in Victoria	Various programs – no evaluation of recruitment or retention
University-Linked Rural Practice	Specific South Australian program	NA
Rural-Based Located Universities	Various state-based centres – no evaluation of recruitment or retention	Various state-based centres – no evaluation of recruitment or retention
Rural Health Clubs	Various state-based centres – no evaluation of recruitment or retention	NA

Of the 21 Australian evaluation studies, 18 were survey- or interview-based and these achieved low scores on the EBR scale (McDonald *et al*, 2002) for their ability to provide evidence-based assessments of recruitment and retention strategies. In addition to low EBR scale scores, the short operation time of many of the Australian initiatives prevented the authors from confirming their success in the recruitment and retention of rural GPs. Short operation time was identified by other authors as an ongoing difficulty for evaluating many Australian recruitment and retention initiatives (Dunbabin & Levitt, 2003) as was inadequate statistical reporting (McDonald *et al*, 2002). Many studies reviewed by McDonald *et al* (2002) were qualitative in nature, and they acknowledged the place of qualitative research in identifying some issues. However, McDonald *et al* (2002) commented that in order to address recruitment and retention problems on well founded knowledge "Australian research needs to progress further and implement well-controlled quantitative research". Wherever it is possible and for the purpose of this study the experience gained from initiatives that have been evaluated will be used, along with the opinions, experience and judgement of key stakeholders in developing sustainable strategies.

Although none of the recruitment and retention strategies contained in the review of McDonald *et al* (2002) (Table 26) were specifically aimed at female GPs, some of them coincide with the themes of some of the changes suggested by the females in this study (Table 6). The strategies of McDonald *et al* (2002) have been matched with the female GPs' suggestions in Table 27, around rural exposure and attitude, locum provision and funding, financial incentives and flexible access to training/CME to demonstrate this coincidence.

Table 27 Review of strategies by McDonald *et al*. (2002) compared with Australian female GPs' suggestions for changes to increase recruitment and retention

Australian, US and Canadian strategies	Australian female GPs
Funded Scholarships (with obligations)	Rural exposure/financial incentives
Preferred Student Admission (rural background)	Rural exposure
Rural Placements (medical students)	Rural exposure
Overseas Trained Doctors	NA
Continuing Medical Education	Flexible access to Training/CME
Locum Relief	Locum provision and funding
Financial Incentives to GPs	Financial incentives
Recruitment Officer/Case Manager	NA
University Linked Rural Practice	NA
Rural-Based Located Universities	Rural exposure
Rural Health Clubs	Rural exposure

Some overseas initiatives have been in place for a longer time than the Australian programs, and have been evaluated for their success as recruitment and retention programs. McDonald *et al* (2002) found that the strength of some evaluations of overseas programs was limited by the same inadequate statistical reporting as the Australian studies. The following overseas recruitment and retention strategies from Table 27 were considered by McDonald *et al* (2002) to be adequately evaluated as 'successful':

- preferred admission to students with a rural background;
- bonded (obligated service) scholarships;
- rural placements (more likely to enter rural practice than non-rural placements);
- CME (retention only and based on GP attitudes); and
- locum relief (based on GP attitudes not recruitment and retention figures).

For the purpose of this project it should be possible to build on the experience gained from 'successful' initiatives that were identified in the review by McDonald *et al* (2002) and that reflected the females' suggestions for change.

In the following discussion specific strategies are reviewed collectively under headings that represent the female GPs' suggestions, to maintain the links represented in Table 27. This format allows the inclusion of the female GPs' comments under each issue in the discussion. The broad headings from Table 27 are Rural Exposure, Flexible Access to Training/CME, Locum Provision and Funding and Financial Incentives.

Recruitment and retention strategies documented in this section have been reviewed in more detail in earlier publications (Adendorff *et al*, 2001; Dunbabin & Levitt, 2003; Holub & Williams, 1996; Humphreys *et al*, 2000; Levitt, 1999; McDonald *et al*, 2002; Norington, 1997; Postgraduate Medical Council of NSW, 2002; Rabinowitz *et al*, 1999), and are included here because of their relevance to any proposals for the recruitment and retention of female GPs in this report.

Rural Exposure

Examination of the enrolment figures for medical students from 1999 showed that females comprised 53% of students commencing medical studies (AMWAC, 2002.1). In 2002 national enrolments of first year medical students from a rural background was 11.5% (Laurence *et al*, 2003). The total national figures are not representative of individual universities' capacity to attract rural students, and the range of first year medical students from a rural background in 2002 was 3.9% (University of Sydney) to 49.8% (James Cook University [JCU]). The location and approach of tertiary institutions (JCU was set up to focus on rural students) is clearly relevant to their ability to recruit students from a rural background. However, the supply of potential students residing in the large metropolitan areas who could be candidates for rural general practice should not be overlooked. There is still an imperative for universities to attract urban students to rural medicine.

The following discussion of strategies that target the broad area of 'rural exposure' covers the period from high school to postgraduate or registrar training.

Studies reviewed by McDonald *et al* (2002) have evaluated programs for high school and undergraduate medical students. The authors grouped them under the following headings:

- Preferred student admission (rural background)
- Rural-based located universities
- Rural placements (medical students)
- Funded scholarships (with obligations)
- Rural Health Clubs

Several initiatives not reviewed by McDonald *et al* (2002) focus on rural exposure for recent medical graduates and are grouped here under:

- Postgraduate rural placements

Preferred student admission (rural background)

In Australia programs that have been implemented to increase the recruitment of medical students with a rural background are relatively new and have so far not shown any evidence that they improve recruitment and retention rates among the rural workforce. However one Australian initiative that targets students from a rural background, the Rural Students Entry Scheme (RSES), has resulted in an increase in rural medical student recruitment, and in their participation in rural based training programs (Adendorff *et al*., 2001).

The Commonwealth Government's RRGPP (formerly the GPRIP) aimed to increase the recruitment of students from rural backgrounds and mirrored two long-term United States (US) recruitment programs (Washington, Wyoming, Alaska, Montana & Idaho [WWAMI] program and the Physician Shortage Area Program [PSAP]). The US studies showed that students with a rural background were more likely to enter rural practice than their metropolitan counterparts. A longitudinal study of PSAP indicated that the overall impact on recruitment and retention remained high after more than 22 years of operation (Rabinowitz *et al*, 1999). The longer running time of the US programs and their apparent success lends support to the implementation and potential success of Australian programs having similar objectives.

Female GP comment: The female GPs surveyed in this study consider that women from rural backgrounds should be encouraged to study medicine, as they will be better prepared for the rigors of rural life and general practice. The continued recruitment of students from rural backgrounds to the study of medicine, with additional emphasis on female student recruits, provides one opportunity to increase the participation of females in the rural medical workforce.

Rural-based located universities

In addition to reforming the student selection process, the original GPRIP included changes to the medical curriculum with the inclusion of some rural components, and enhancement of support systems for training students in rural medicine. The Commonwealth Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme assists rural medical students with living costs during their medical training, as a further initiative to increase the rural GP workforce. The staged establishment since 1996 of University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) has enabled students from rural backgrounds, or urban students with an interest in rural health, to study in or near their area of interest. The presence of these institutions will increase the numbers in the rural health workforce, and the indigenous and non-indigenous rural communities' access to them (Humphreys *et al*, 2000). The short operating time frame of the UDRH and RCS has not allowed for any evaluation of their effect on the recruitment and retention rates of rural GPs.

Female GP comments: The female GPs identified the potential benefits of early exposure to rural practice with a mentoring component. The UDRH provide the opportunity to study and work in a rural environment under the guidance of skilled mentors. It is not clear if females are specifically recruited for inclusion in these programs.

Rural placements (medical students)

Exposure to rural practice during medical training is reported to influence medical graduates' choice of a rural practice (Norington, 1997). Australian students who undertook rural placements during their medical degrees expressed their intention to pursue rural practice at a higher rate than students who did not experience a rural placement. Studies on rural placements during medical training largely measure student attitudes and the effect on recruitment and retention is not known (McDonald *et al*, 2002). The Commonwealth Government and the state and territory heath departments provide incentives by funding travel and accommodation for medical students who undertake rural placements. Studies on the benefit of rural placements in the USA and Canada, confirm that students who experience rural placement are more likely to take up rural practice, but these studies have limited value due to the inadequacy of their evaluation methodology (McDonald *et al*, 2002).

In addition to the provision of training for rural students, the UDRH and RCS facilitate longer term placements for medical students in rural areas and provide access to experienced staff. Through the Rural Undergraduate Support and Coordination (RUSC) program, the Commonwealth Government provides funding to universities for travel and accommodation to support medical students who undertake rural placements. As part of the medical curriculum Australian universities require students to spend varying amounts of time in a rural area, and since the funding and establishment of the RCS it has been possible for students to take extended rural placements. In addition, a number of scholarships and bursaries also provide rural experience through placements, for example Bush Bursaries, County Women's Association (CWA) and John Flynn Scholarships, as well as a range of scholarships that are available to students of particular universities.

Female GP comments: The female GPs believed in the positive benefits of exposure to rural practice and life during medical undergraduate training. They suggest that this exposure might be achieved through placements with other female GPs who have adapted successfully to rural life and work, and who could act as role models and mentors for potential new female GPs. Some were convinced that early exposure to rural practice was essential to being adequately prepared for it, and to the successful recruitment and retention of rural female GPs.

Bonded scholarships

The Australian State Governments variously offer scholarships to medical students who are subsequently bonded to a rural or remote area after completion of their medical degrees for a time determined by the structure of the scholarship scheme in each State. The Commonwealth Rural Medical Bonded Scholarships scheme bonds graduates for six years to a rural or remote area after they complete their basic medical training and GP or specialist fellowship. McDonald *et al* (2002) were unable to comment on the efficacy of these programs due to the absence of adequate evaluation of their success. A similar program in the US (National Health Service Corps) has not been well evaluated due to the inadequacy of the statistical methodology applied in the studies but it appears there is not a great difference in retention rates between bonded and non-bonded students.

Female GP comments: Some of the females felt that bonded scholarships are one way of introducing medical graduates to rural life and practice. While this type of program may work well for some individuals, McDonald *et al* (2002) comment that participants have lower morale and work satisfaction, although they do make a huge contribution during their bonded service time. The issues that currently face female GPs, availability of part time work, spouse employment and secondary education for children, could well be exacerbated if the females were bonded to a rural or remote area for an extended period. From that point of view the program could even work against the overall recruitment of female GPs to rural locations.

Rural Health Clubs

Rural Health Clubs (RHC) support undergraduate students with a variety of planned activities and provide links between students with common interests in a rural career. These student activities have not been evaluated although students generally provide positive feedback to the organisers (McDonald *et al*, 2002). In NSW, the RHC promote rural health careers to high school students through joint programs supported by NSW RDN, Rural Health Training Units and the participating RHCs. Similar programs are sponsored by the Western Australian Centre for Remote and Rural Medicine (WACRRM) and GPPHCNT. The Victorian Universities Rural Health Consortium (VURHC) and the RDWA in SA both have active high school programs. The programs have not yet been evaluated for their impact on recruitment of students into medical studies.

Postgraduate rural placements

Several Australian initiatives target recent medical graduates. Regionalisation of the GP Training Program is the most recent change to the support provided to registrars in the rural pathway. The Higher Education Contribution Scheme (HECS) Reimbursement Scheme allows medical graduates to work off their HECS debt by practicing in a rural area. Neither scheme has been evaluated for its effect on recruitment and retention.

The Rural and Remote Area Placement Program (RRAPP) is one of a number of strategies that attempt to increase the exposure of recently graduated hospital interns to rural general practice. The Australian College of Rural and Remote Medicine auspices RRAPP on behalf of the Commonwealth Government, and has undertaken a preliminary evaluation. Participants rated the RRAPP as a successful program in providing training opportunities and support to junior doctors (ACRRM, 2003c).

Additional rural postgraduate placements include terms in regional, rural and remote hospitals, and rural community placements. The Postgraduate Medical Council of NSW (2002) reviewed these options for the Commonwealth, and a number of recommendations accompany the review.

Female GP comments: Female registrars who responded to the national survey raised some issues specific to their circumstances. They were interested in having access to part time registrar positions to be able to fulfil commitments to their families, and to enjoy the quality of life that working in a rural area allows. They also had issues with respect to employment opportunities and support for partners who accompanied them to their rural placements. The female GPs believe that recruitment and retention of females to the rural GP workforce would be enhanced by early exposure to rural life and practice in conjunction with a formal support program.

Flexible Access To Training/CME

Several inconclusive overseas studies on the effect of CME were reviewed by McDonald *et al* (2002). Participants in the Additional Skills Training and Enrichment Programs in Canada believed that the programs improved recruitment and retention but the evaluation studies only measured the participants' perceptions. In Alaska, surveys of participants in CME programs indicated their preferred topics and mode of access, and specifically the use of distance training methods by remote area physicians (McDonald *et al*, 2002).

Over the last decade in Australia, rural and remote GPs have had greater access to Continuing Medical Education (CME) programs in response to the requirement for GPs to undertake vocational registration (Hays & Piterman, 2000). Uptake of CME through the RACGP Quality Assurance and Continuing Education program is linked to GPs ability to access funding incentives. As a result research has been undertaken to determine the how the program affects participation rates, and to try and evaluate the effectiveness of the program on recruitment and retention. One of these studies by Strasser *et al* (1997) involved a survey of rural GPs to determine their involvement in seven training and support programs. The study found that 85% had involvement with at least one program, and the majority had involvement in one to three programs. Females and males were equally involved in one or two programs but females were less likely than males to be involved in more than two programs. Strasser *et al* (1997) found that female GPs were less aware of the seven training and support programs and concluded that if females were more aware of the support systems available to them they might even participate at a higher rate than the males.

McDonald *et al* (2002) reviewed studies that looked at GPs preferred modes of learning and access to electronic information. They found that evaluating the efficacy of the program in rural areas was difficult because GPs were not always able to attend face to face events, or were not able or willing to use the electronic alternatives. Overall the studies reviewed by McDonald *et al* (2002) did not measure the effect of CME on recruitment and retention but rather measured GP attitudes to teaching methods and changes in their own skill levels after accessing CME. Thus it was not possible to claim that greater access to CME has improved recruitment and retention of rural GPs.

The National Female Rural General Practitioners Research Project (Tolhurst & Lippert, 2001) has embraced the female GPs responses by including four recommendations around the area of flexible training arrangements for re-entry and upskilling of female GPs and GP registrars. In their study of the strategies that females use to maintain a sustainable rural practice Wainer *et al* (2001) found that the most important strategy identified by an expert panel was to have and maintain current professional expertise. When asked to rate a number of strategies the panel placed a flexible practice structure above professional skills. However it was clear from the Wainer *et al* study (2001), and from the female GPs responses in this study, that having a flexible practice was inextricably linked to the females' ability to access training.

Female GP comments: The finding by Strasser *et al* (1997) that female GP participation dropped off beyond two training and support programs was confirmed by the experiences of the female GPs. They had problems accessing training because of their additional responsibilities of childcare and family support, and the demands of their work. The females were keen to improve their skills and to have vocational registration but were inhibited by inflexibility in their practices and in the system generally. The problems of access were identified consistently by females who were not merely interested in gaining CME points but who wanted to undertake postgraduate training and substantial upskilling in specialist areas of medicine. Another group of females were identified in earlier research who wanted retraining on their return to the workforce after time away, when moving from part time to full time practice or who needed to develop skills in leadership, assertiveness and negotiation (Tolhurst *et al*, 1997; McEwin, 2001).

Locum Provision and Funding

A mobile locum service trialled in New Zealand was considered to be a successful model by both locums and practitioners using the service. The service was piloted among a small group of GPs making it difficult to determine its value as a large-scale initiative (McDonald *et al*, 2002). An on-call locum service in Alberta, Canada that operated as a remuneration scheme worked well in communities with small numbers of physicians. Between 1998 and 2001 over 600 physicians accessed the program, but in spite of claims by participants of greater retention rates there was no statistically sound evidence to support those claims (McDonald *et al*, 2002). McDonald *et al* (2002) suggested that there might be benefits to physicians as a result of the reduction in workload and professional isolation provided by the program. These two factors have been identified as the major issues preventing Australian doctors from

remaining in rural practice in the long-term (Hays *et al*, 1997; Kamien, 1998). It is reasonable to expect that such a successful remuneration scheme could have long-term effects on recruitment and retention of GPs in rural locations (Humphreys *et al*, 2002b).

Locum services provided through Queensland and NSW RWAs, 'AMA Locum Service' in WA, and the Commonwealth Rural Locum Relief Program (RLRP), were cited by McDonald *et al* (2002). However, they were unable to find any formal evaluation studies to determine the effectiveness of these programs or of any other Australian locum relief programs. There are a number of commercial state-based service providers and at least one national 'on call' provider that recruit doctors for long- and short-term placements. Most of these have been relatively recently established and their effect on recruitment and retention is unknown. The NSW RDN implements several locum initiatives with the greatest number of locums being provided through a pool of overseas-trained doctors. While these initiatives do provide some female locums the service does not get special requests for female locums either from the general practices or from individual female GPs (NSW RDN pers. com.).

The provision of locum services to rural areas will be an ongoing need with potentially expanded activity as new recruits to the rural GP workforce increasingly expect to take leave for professional development, personal and recreational purposes. The women's health aspects of general practice will continue to require female locums as long as female patients prefer to see a female GP (AMWAC, 1996) when their regular female GP is on leave (Tolhurst *et al*, 1997; McEwin, 2001; Wainer, 2001; White & Fergusson, 2001; Roach, 2002; Tolhurst & Lippert, 2003).

Female GP comments: When asked about a range of areas that were important for job satisfaction the female GPs nominated after hours locum cover among their top five priorities. Similarly, in response to the survey question about changes that would improve recruitment and retention of rural female GPs, the females rated locum cover for a variety of purposes, including attendance at CME and other events, and time off for school and family holidays, among their top five priorities. The female GPs report that their female patients will often wait for their return from a break away rather than see a male GP. This results in an enormous workload and potentially poor health outcomes for their patients. Taking time away from the practice becomes a disincentive for attending training programs and networking events that are not viewed as urgent by female GPs.

Financial Incentives

Assessments of overseas studies that attempt to determine the effect of financial incentives on recruitment and retention of rural physicians are limited by the same issues as Australian studies, that is separating the combined effects of financial incentives and other benefits on recruitment and retention outcomes (McDonald *et al*, 2002). The Commonwealth's GPRIP was an initiative that aimed to address short- and long-term recruitment and retention issues in rural Australia by offering financial rewards to GPs who practiced in rural areas. Many of the programs evolving from GPRIP were based on a mixture of financial incentives, and enhanced opportunities to practice in rural locations, and included grants for relocation, family support, training, CME and associated costs, remote area practice and equipment (Holub & Williams, 1996). As a result McDonald *et al* (2002) have found it difficult to assess the effect of financial incentives alone on recruitment and retention.

An Australian study of GPs investigated the link between their involvement in the GPRIP and the average length of time they had spent in their current medical practices (Strasser *et al*, 1997). The results showed that non-participants in GPRIP were in their current practices longer than participants in the GPRIP, and Strasser *et al* (1997) concluded that the GPRIP and its financial incentives had no demonstrable effect on retention rates.

Female GP comments: The females in this study had a variety of concerns about financial issues. Although they did not rate financial incentives alone among their top priorities for change, the females in this study had issues around remuneration for attendance at CME events, in terms of costs of childcare, travel and locum relief. The females suggested that tax incentives or some other form of remuneration for the cost of childcare for after hours and on-call, and the cost of educating their children at high school would increase the viability and sustainability of their rural practices. They also sought recognition through Medicare item numbers of rural specific health issues and of the longer consultations that female GPs conduct (AMWAC, 1996.7; Wainer *et al*, 2001; Tolhurst & Lippert, 2001). Long consultations were seen to reduce practice income and as a result the females often encountered negative attitudes from their male practice colleagues. Locum provision and funding for cover during school and family holidays, maternity leave and training was the third priority on the females' list after flexible work

opportunities and childcare. However the cost of locum cover was a disincentive for the females. More than half the rural female GP workforce is part time (ARRWAG MDS, 2002), and anecdotal evidence confirms that female GPs are more likely to be salaried than partners or associates in a practice. The female GPs reported that their part time and salaried positions appear to reduce their access to Practice Incentive Payments even though they regularly address and follow up multiple health and psycho-social issues with their patients.

Recruitment and Retention Strategies For Female GP

The qualitative research conducted by Tolhurst and Lippert (2001) complements the RWA surveys and other recent research around the workforce issues confronting rural female GPs. The authors have documented a number of models (Table 28) and strategies (Table 29) that are currently being implemented by a range of stakeholders. Tolhurst and Lippert (2001) have provided these examples of 'innovative' practice models because they offer flexibility to GPs who work in areas where recruitment and retention are difficult.

The practical nature of these strategies provides a novel and thoughtful approach to changing the historical model of general practice by injecting a high level of flexibility into the workplace, thus giving females and males the freedom to care for their patients and spend time with their families. These strategies provide an opportunity for GP support agencies and other key stakeholders to consider ways in which they can offer different kinds of support in developing practices that enhance the lifestyle and health outcomes for GPs and the community.

The strategies identified by Tolhurst and Lippert (2001) in Table 29 correspond to four of the 12 groupings of changes suggested by the female GPs in this study (Table 6). They include CME, childcare, support networks and locum cover, and are largely provided by the DGP, with some initiatives provided by the RWAs.

Table 28 Flexible practice models for rural and remote female GPs

Model	Detail
Solo practice – public sector	Magnetic Island model (MORPP) – shared salaried position in one-GP town, 0.6 FTE per GP (of 2); savings on locum costs means cost neutral
Remote area – public sector	Kowanyama Job Share Model (RFDS) – 2 GPs have 14 days on – 7 days/week & on call; 14 days off (0.8 FTE)
All female practice in regional centre – private sector	Flexible hours to accommodate family and work demands with all principals female and working part time; shared after hours; equal share in practice and according to individual earnings
Part time for male and female principals – private sector	Six principals, 3 female and 3 male, all part time for varying amounts of time; equal ownership of assets; practice costs according to proportion of earnings; shared after hours/ on call/holiday cover

Table 29 Strategies implemented by GP organisations for rural and remote female GPs

Organisation	Female GP issue	Strategy
DGP		
	CME	• Identified by females as priority issues – mental health, pregnancy care, birth forums, tropical disease, GST, managerial issues
		• Retraining for re-entry
		• Social component included for networking
		• Held at different venues to increase access
	Childcare	
		For CME and other events – full or limited or on request. Around 50% of DGP stated they do not provide childcare for CME
	Support networks	• Monthly, quarterly, annually dinner/social meetings; sometimes with speaker on clinical or non-clinical subjects
		• Stress management workshop
		• Funding for GPs to attend interstate conferences
		• Mentoring new female GPs with existing females
		• Leadership opportunities within Division
		• Survey to determine needs
	Locum	Funding to provide female locum cover
RWA		
	CME	Leadership training week-ends
	Support networks	Quarterly dinner meetings

Recruitment and Retention Strategies Identified by Female GPs

Roach (2002) cited a number of initiatives in her report for WACRRM titled 'Female General Practitioners in Remote and Rural Western Australia' that fall under the groupings of flexible work opportunities, support networks, family issues, childcare, CME and financial incentives (Table 30). None of these include evaluations and some have an identified caveat. For example, in some larger centres the increased recruitment of hospital doctors has alleviated the 'on call' requirements for GPs but has the potential to reduce the number of GPs with procedural skills. In some areas the GP has to pay for the hospital doctor to attend the 'on call' request, and this is a disincentive. Although these initiatives have not undergone critical evaluation in Roach's report, nor are they all specific to females, they are relevant when considering strategies for this study because they have come about from discussions with and by females about rural and female issues.

Table 30 Recruitment and retention initiatives identified by Roach (2002)

Female GP issue	Detail	Outcomes
Flexible work opportunities	Shared after hours roster part of work contract arrangements	Hasn't worked that well & depends on individuals
	Local hospital doctors cover GP on call	Cost to GP
	Virtual amalgamation of small towns – Three Springs, Morawa, Perenjori, Eneabba & Coorow – doctors share after hours, visit small towns, share workspace with allied health, and patient information available on computer after hours.	To be evaluated but hoped will improve retention rate
	Gascogne health service introducing computerised medical records with private practice and AMS amalgamating	Pilot for evaluation
	Local government – Ravensthorpe Shire have developed new initiatives	No details but likely to be corporatisation model and local government consultation
Financial incentives	Evolving arrangement in Karratha and Broome of salaried employment versus private practice	Possibly more attractive to females GPs May not suit patients May disrupt continuity of care
	Northwest Hospital Doctors workplace agreements	Possibly more attractive to females GPs
	Corporate practices – improve financial position by providing salaried positions	Potential loss of job satisfaction
	Reported obstetric insurance for GP paid by some hospitals in eastern states to help them break even on deliveries	Anecdotal and not verifiable
Support networks	Working well for Karratha GPs who contact specialists in Perth by telephone for advice on complex cases	In situ and working on a local basis
Family issues	Offering golf days, landscape gardening & outdoor excursions for males spouses	Better received than networking or focus groups
Childcare	Carer stays with children at home	Only useful for standard hours as provided by Family Day Care
CME	Home based TV and satellite broadcasts – convenient and valuable option	Discourages networking and encourages isolation

Chapter 7 Proposed Strategies to Increase the Recruitment and Retention of Females in the Rural and Remote GP Workforce

The outcomes of this study have particular relevance to the RWAs in all Australian states and the Northern Territory because they directly relate to their core business around workforce issues. All female GPs working in rural and remote Australia were sent surveys by the RWAs to identify barriers to their participation in the rural GP workforce and to determine the relevance of existing initiatives to female GPs. While the RWAs will use this information for their recruitment and retention programs, there is a range of other stakeholders that provide support services to rural GPs for whom this report is relevant.

Examination of the literature, and the websites of GP support organisations, shows that many different groups provide support to rural GPs through a variety of strategies. However, in an environment where evaluation as a measure of success has been largely under-utilised, or is premature given the short time span of some programs, it is not a simple matter to determine the most effective of the existing strategies. Earlier studies on the issues confronting rural female medical practitioners have produced a series of recommendations based on their findings (AMWAC, 1996; Tolhurst *et al*, 1997 & 2000; RACGP, 2000; Tolhurst & Lippert, 2001; McEwin, 2001; Wainer, 2001; Wainer *et al*, 2001; Roach, 2002; Greenwood & Cheers, 2002; Kilmartin *et al*, 2002; White & Fergusson, 2001). Tolhurst and Lippert (2001) identified a number of organisations and individuals who have devised models with the specific purpose of meeting the recruitment and retention requirements of rural female GPs, or that can be modified to suit the preferred work practices of rural female GPs.

The intention of the discussion that follows is to exemplify current approaches to recruitment and retention so that the experience gained from these approaches can be used by the readers in resolving some of the issues identified by the female GPs in this study. The suggested approaches contained in Table 31 are relevant to individuals and organisations involved with or having an investment at any level in the rural medical workforce.

Table 31

The following table is laid out in a format that can be used as a reference for GP support organisations, and individuals who are engaged in strategic planning for the recruitment and retention of female GPs. The 'Existing Strategies and Models' column contains a range of strategies that are accessible to female and male GPs, and that are currently provided by a number of stakeholders including the RWAs, DGP, RDAA, ACRRM, Commonwealth and state health departments, training organisations, local health services and other GP support organisations and individuals. The column sub-headings (flexible work opportunities, childcare etc.) are consistent with the headings used throughout the report and cite existing (although not all) strategies that could be employed to address a particular recruitment and retention issue represented by the heading. 'Actions Required to Increase Relevance to Females' are suggestions based on the female GPs' responses and the literature. In the 'Synergy with Female GP Survey Responses' column the link between the female GPs responses to the survey questions and the actions proposed in the previous column is made. The final column 'Organisations and Stakeholders' is included to assist the reader to identify potential providers or partners who might have an interest or investment in implementing strategies around the proposed actions.

The list of strategies detailed in Table 31 is not exhaustive and is not intended to infer irrelevance by the exclusion of any strategies that are operating at this time.

Table 31 Recruitment and Retention Strategies

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
Flexible work opportunities	**Provide a flexible workplace that accommodates multiple roles of female GPs**	**Implementation of flexible work opportunities will:**	
• Sustainable Models Grants • Practice management grants • Job sharing models • Fly-in Fly-out female GPs • NSW all female practice • NSW all part time GPs • WA Shared after hours • WA cover for exceptional circumstances or regular time off for 1x GP practice • NSW RDN practice identities • Doctor's surgery/residence owned by local government or community	• Encourage stakeholders to become involved in maintaining GP services in the community • Increase incentive to make practices more flexible & viable • Introduce rosters & structures that make job sharing attractive & equitable • Provide accommodation for more than one GP in town • Promote part time as option for all practices with more than one GP and with female GPs in practice • Promote benefits of shared after-hours roster to doctor & patients • Develop 'hours' bank for holidays, training, time-out • Doctors employed by local hospitals have agreement with GP to provide cover and supported by all stakeholders	• Increase sustainability of practices with greater flexibility, patient access, job sharing, and part time female GP participation • Improve practice management with greater efficiency and improved profit. Female GP contribution respected for patient outcomes versus monetary value • Increase ability of female GPs to work part time even in one GP practice • Provide incentive to job share if appropriate accommodation provided • Provide opportunity for women's health specialists to share skills among female patients • Provide option for female GPs wanting to escape male dominated culture • Allow working in flexible environment of acceptance, shared workload, shared overheads • Increase predictability of work load • Provide load equitable with PT hours • Reduce guilt and attitude from colleagues • Allow time off without disadvantage to patients and family	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
Support Networks	**Ensure personal and professional support for GP and family**	**Providing GP and family support will:**	
• RWA orientation program for new female GPs & family • Mentor support • Family support • GP partner employment & training • GP partner employment opportunities • RWA counseling service & site visits • RWA employment support service • RWA & AMA standard work contract • Accounting & financial management support • RWA supports community to recruit GPs • RWAV incentive grants to support (12) communities in recruiting GPs • Networking events • RWA wellbeing programs • Involvement in multi disciplinary team around clinical issues • RMFN programs • WACRRM bulletin board for female doctors on website	• Promote programs for female GPs and family • Increase opportunities to participate in mentor program for new female GPs and GP registrars • Increase childcare and family activities at CME • Provide practice management and accounting training, and business technology for GP partners • Establishment of local childcare service • Work from home opportunities • Provide services to GP and family to address own problems as needed • Available referral services for patients • Negotiate on behalf of female GPs with employers and other stakeholders during entire employment process • Make standard contracts available option to salaried female GPs to ensure equity • Provide support to ensure practice and career remain viable • Engage communities that struggle to attract and/or retain GPs and promote female GP and part time as options to traditional model • Assist community to take responsibility for recruitment and retention using local approaches	• Ensure adequate preparation of family for new life style • Allow sharing of local experiences while providing support and helping to build GP confidence and skills • Help to overcome difficulties for female GPs in accessing CME • Resolve problems around employment availability for partner • Resolve problems around own practice management issues • Female GP and community both benefit from childcare • Support female GPs to manage family and practice issues and support family in overcoming isolation or other problems • Increase access to referral services • Address lack of skills in negotiating employment contract and conditions • Ensure entitlements are included in contracts • Assist when female GPs lack skill or confidence to negotiate contracts and conditions • Assist where female GPs lack skills and knowledge to manage practice	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Rural Medical Family Network • Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
	• Organise regular dinner meetings and female sessions included in CME and conferences. Provide speakers if requested by females • Target female GPs for maintenance of health and wellbeing • Initiate or participate in a group to manage serious and specific clinical issues • Disseminate information about facilities and research into specific disease **Additional actions identified by stakeholders** • With increase in female GP numbers RMFN may need to increase male presence in organisation	• Community will support female GP because it has ownership of recruitment process and has applied local solutions to recruitment and retention • Reduce isolation by providing debriefing, socialising, sharing of experiences and friendship opportunities • Improve access to care for their own health and wellbeing needs, improve support in specific areas e.g. post-natal and return to work • Provide support in managing complex health issues from diagnosis to post intervention management • Encourage proactive management of illness and disease prevention	
Childcare	**Make flexible childcare more accessible**	**The benefits of accessible childcare are:**	
• Camperdown model, Victoria (Scott, 2003) • Mobile service • Informal models	• Promote the Camperdown model to local government and community organisations as it benefits the GP and community • Provide accredited and accessible mobile service for planned events • Promote mobile service as possible business opportunity for GP partner • Encourage individuals in community to form 'granny' roster • Engage community organisations like the CWA to participate in childcare rosters	• Reduction in role conflict and female GPs can participate in workforce and training opportunities at the level they prefer • Ability to attend networking and training events where childcare not usually available • Development of extended families, reduction in isolation, reduction in role conflict and guilt	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Rural Medical Family Network • ACRRM/WIRP • Rural Hospitals and Health Services • State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
Financial Incentives	**Raise awareness of available support and grant**	**Providing financial support programs will:**	
• Medical indemnity payment assistance • Relocation grants • Remote area grants • Orientation grants • Remote practice & community training grants • Practice management grants • Remote practice locum support grants • Funding to attend women's health conferences	• Promote availability of indemnity assistance to female GPs who want to continue practicing anaesthetics and obstetrics • Raise awareness of female GPs to available grants • Promote remote practice support to female GPs who are interested in remote area work • Assist female GPs by encouraging professional development and upskilling	• Help females to maintain skills in specialist areas • Encourage females to upskill and reduce their relegation to part time, non-procedural GPs • Increase incentives for females to work in rural and remote locations • Increase opportunities for female GPs interested in Indigenous health issues and remote community work • Increase preparedness for remote work and reduce stress and adaptation time • Improve female GP's ability to undertake remote practice and contribute to Indigenous communities • Assist in setting up practice to increase viability • Increase retention by providing opportunity to take leave • Increase job satisfaction, skill levels and confidence in rural practice	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Rural Medical Family Network • Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Doctors Association of Australia and State bodies • Commonwealth and State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses
Flexible access to training/CME	**Provide female friendly training programs**	**Implementation of flexible training with relevance will:**	
• Training & retraining grants • CME • Training for self health programs • RWA education websites • RRMEO – web based option	• Provide 2/3 female trainers • Include 70% female participants in training • Provide childcare • Make easily accessible (not too far to travel)	• Meet concerns about lack of preparedness for rural and remote practice and increase confidence on return after break away from practice	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
• FLAME – Victorian Rural Emergency Medical Training for Female GPs • Female PD weekends • Gender conferences • Cairns DGP monthly w-end seminars – 'Lady Doctors Association' • RDWA SA annual practice management seminars • Training in women's health • WACRRM satellite broadcasts & home TV links • NSW RDN satellite dish internet project • WACRRM CME in negotiation skills for females • RWAV training audit to include every possible training source and be posted on Education page of website • RDN & RWAV leadership training week-ends	• Provide in modules so one module can be completed in one session • Maintain relevance to female GPs and their patient group e.g. pregnancy • Provide other needed training e.g. leadership, assertiveness • Ensure training is confidence building and not undermining • Include process for assessing trainers and if undermining they can be replaced	• Provide access to audio or video training programs from home at preferred times if travel to CME is not possible • Respond to topics of high need in rural areas and nominated by female GPs • Encourage female GPs to expand their skill base and increase their independence • Provide access to conferences for female GPs; interested males may learn from exposure to gender issues • Increase opportunities to participate in decision making roles • Provide local networking and training opportunities that are highly valued by female GPs in feeling supported and less isolated • Increase ability to manage complex health issues in isolation or with remote support **Additional benefits not specifically identified by female GPs in the survey** • Improved practice management a benefit to female GP principles and to part time female GPs • High rates of suicide make self mental health care a priority	• Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
Attitudes to female medical practitioners	**Increase female participation in leadership roles**	**Having females in policy and decision making will:**	
• Representation on organisation Boards and in policy making positions	• Continue to promote females as board members of colleges and GP support organisations • Build female executive component into organisational constitution • Actively seek females for other leadership roles • Experienced female mentors can provide support to other females wanting to take on leadership roles • Continue to put female representation on the agenda	• Increase opportunities to raise a more inclusive range of issues • Address the imbalance in gender representation at all levels	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments
Locum Provision and Funding	**Raise awareness of benefits of locum access and locum work**	**Use of locum services will:**	
• Find and subsidise locums for short and long term needs • Locum support for maternity leave • Remote practice locum support grants	• Promote locum services to female GPs for training and networking opportunities • Promote support grants to female GPs contemplating remote placements	• Increase opportunities for females to upskill, undertake postgraduate training, take family holidays and in crisis • Reduce role conflict and negative attitudes of colleagues • Increase retention by providing opportunity to have breaks	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
	Additional actions identified by stakeholders • Promote locum as resource and job option as female locum requests and availability are variable across states • Promote Overseas Trained Doctor program as a good source of female locums		• ACRRM/WIRP • Rural Hospitals and Health Services • Rural Doctors Association of Australia and State bodies • Commonwealth and State Departments of Health • Local Governments
Rural Exposure and Attitude	**Increase opportunities for females to experience rural life and practice**	**Exposing young females to rural life and practice will:**	
• Rural high school recruitment program • Rural Health Clubs (RHC) • Scholarships, Bursaries & Cadetships • Travel & accommodation subsidies during rural placements • GP Registrars Rural Incentive Payments (GPRRIP) • Rural Student Entry Scheme (RSES)	• Target females to increase participation in RHC and uptake of scholarships and subsidies • Increase flexibility of GPRRIP to include part time and family considerations for female registrars • Increase focus of RSES on female students **Additional actions identified by stakeholders** • Ensure that rural training placements are viewed as valuable experiences by colleges and specialist consultants • Trainees at all levels are protected from harassment and discrimination on the basis of gender • Encourage all training bodies to promote rural placements as valuable experiences	• Help to develop interest and understanding of rural life and practice and prepare females for it • Respond to female GP comments that early rural exposure to the life and practice would be valuable • Provide professional and personal support in rural practice during training years • Offer preferential selection on the basis of their rural backgrounds	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Rural Medical Family Network • Training organisations – Universities, University Departments of Rural Health, Rural Clinical Schools, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses

Table 31 Recruitment and Retention Strategies continued

EXISTING STRATEGIES & MODELS	ACTION REQUIRED TO INCREASE RELEVANCE TO FEMALES	SYNERGY WITH FEMALE GP SURVEY RESPONSES	ORGANISATIONS AND STAKEHOLDERS
Safety	**Prepare females for unsafe situations**	**Safety increased by:**	
• Anecdotal – after hours GP services provided from hospital • Anecdotal – partner accompanies GP on after hours visits • GPPHCNT orientation program • RACGP accreditation standard 5.1: 'The practice has facilities which are appropriate for General Practice and which promote the health, safety and comfort of staff and people who use the practice'.	• Provide training in workplace safety and security • Promote orientation program to female GPs contemplating remote practice • Ensure that practice follows RACGP guidelines for safety and security **Additional actions identified by stakeholders** • Awareness that sources of danger can include colleagues • Dangerous patients may not be easily recognised • Family and GP residence at risk from intruders searching for drugs	• Understanding behaviours like stalking that can occur anytime • Avoiding isolating situations and have access to back-up • Training in avoidance and management of unsafe conditions • Following RACGP guidelines for security in the workplace • Orientation to improve understanding of Indigenous culture & language • Increasing driving skills	• ARRWAG and State and NT Rural Workforce Agencies • Divisions of General Practice and State-based Divisional organisations • Rural Medical Family Network • Training organisations – Universities, University Departments of Rural Health, RACGP, Training Consortia and others • ACRRM/WIRP • Rural Hospitals and Health Services • Rural Primary Health Care Providers • Rural Doctors Association of Australia and State bodies • Australian Medical Association • Commonwealth and State Departments of Health • Local Governments • Rural Communities • Local Rural Businesses

Flexible Work Opportunities

The common theme throughout this study is that female GPs need flexibility in their working environment. The nature of their work limits the females' ability to be flexible themselves and the additional responsibility of family care compounds the problem. The onus of sustaining a flexible environment for female GPs is likely to fall on their support systems, including the family, the practice partners or employer, workforce support agencies and communities. The structure and nature of these support systems makes some of them inflexible too, and renders resolution a difficult although not impossible task.

The most popular option to increase flexibility is to work part time, and around one half of the female GPs have made this choice. Flexible models that were documented by Tolhurst and Lippert (2001) described job sharing in a remote location, which would work equally well in any location, with some modifications to suit the local conditions. Those authors also described a northern NSW coastal practice employing only part time GPs, that is built on the premise of equity and fairness, and acknowledgement of the GPs' personal life and interests. The inflexibility of a solo practice in rural areas would be reduced by the introduction of a second practitioner or regular locum where possible. In a single GP community the case has been described where a second residence was acquired for an additional GP, and remained the property of the community or the local council. Having a community owned residence increased the appeal to incoming GPs who appreciated the opportunity to assess their interest in, and suitability for the practice, before deciding on a long-term commitment to the community.

Sharing the burden of after hours work was another difficult and contentious area for female GPs with family responsibilities. Consideration could be given to ways of managing after hours work by increasing flexibility, including sharing the load within the practice and between practices. In some states, hospital doctors take on after hours cover for local GPs by arrangement. Having a 'bank account' of after hours relief that can be accumulated to cover a period of leave when required, is another flexible approach to after hours work. As Roach (2002) discovered in her discussions with female GPs in Western Australia the opportunity for negotiating flexible work arrangements was largely dependent on the cooperation between the individuals involved. Anecdotal reports from female GPs indicated that they did not always feel strong in negotiating their work conditions but made no mention of approaching their GP support organisations for assistance with these matters.

Female doctors work fewer hours than male doctors throughout their working lives, but male doctors are increasingly reporting their wish to reduce their hours and some data suggest that this is already happening (AMWAC, 2000; Hirsch & Fredericks, 2001). Introducing change to the existing culture of rural general practice will require broad acceptance within the medical profession and its largely male dominated organisations. The concept of female medical practitioners having different and additional work participation issues than their male colleagues, which impact on their ability to practice medicine according to the generally accepted model, has yet to be openly acknowledged within the medical profession.

Support Networks

Female GPs have identified their need for support networks in their professional and personal lives. In order for them to fulfil their multiple roles as women in their communities, as mothers, wives and doctors they require support for and from their families, and from colleagues, the community and professional organisations. The need for this breadth of support is not reported by male GPs to the same extent, as they mostly have wives who support them.

While the strategies listed in Table 31 have general applicability and could be readily accessed by some female GPs, the females in this study and earlier studies have clearly voiced their specific requirements to balance their multiple roles. Anecdotal reports from female GPs, and findings from this survey, identified one popular approach to supporting females through informal networking opportunities. It can be a simple and inexpensive regular meeting of female GPs from within a DGP or in a smaller geographic area, with a large social emphasis and may include additional input from guests or speakers on any topic of the females' choice. A number of DGP already do this for female GPs in their area and other rural Divisions could find that this is a popular event with their female GPs.

Local communities can also be part of the female GP's network by helping the females to become integrated into the community, involving them in events along with other women and mothers, and by providing the space for them and their families to be part of general community life. This sort of support requires very few resources. The ACRRM (2003a) pilot to develop a model for a national female GP mentoring program for GP registrars, currently being conducted by the Victorian and Queensland RWAs, is limited to GPs in training and requires a more structured and resource intensive approach.

Cheney *et al* (2003) point out that when trying to improve support services and mechanisms for the female GP the needs of the whole family must be considered, as well as the benefit to the community. It is possible that other members of the community share the same support needs as the female GP. For example, in a community with a high unemployment rate it may be difficult to gain support to help find employment for the GP's partner when people in the community cannot find work. A sensitive approach would be required to recruit community support and to provide some benefit to the disaffected community members.

Nearly half of the female GPs were employed by an individual or organisation, rather than being practice partners or associates. There is an opportunity for employers and support organisations to review the issues identified by the females in this study and engage in long-term planning to support female GPs and increase their recruitment and retention in rural areas. The number of females who were not affiliated with a college was discussed in Chapter 5. These organisations also have the opportunity to demonstrate their relevance to their potential client base. New female recruits to rural practice might understand the relevance better if they were offered reduced membership fees in their first year of practice, with some additional support included. Both parties benefit if the incentive has the outcome of informing and supporting the new female GP recruit.

Childcare

This is one of the top priority issues for female GPs, and one that impacts on their ability to fully participate in their work and training environments. As a result, it is a critical provision for nearly every recruitment and retention strategy for rural female GPs. While some DGP and RWAs have provided childcare for CME and other events there is increasing doubt about their ability to continue to do so in the current environment of insurance and liability concerns. The loss of such an essential service would be disastrous for rural female GPs who already experience difficulties with access to work and training because of their family commitments.

An exemplary cooperative initiative that has overcome the childcare issues described above is the childcare service in Camperdown, Victoria. It involved the hospital and the local council and was set up initially for the hospital nursing staff and was subsequently made available to all medical and other health staff and to the general public. Planning for the service included the provision of after hours childcare to cater for the needs of staff on shift work or on call (Scott, 2003). This is a model that could well be duplicated in other similarly sized towns. Another proposition for providing childcare at various training and other events was a mobile service. This would entail appropriate business planning and meeting accreditation requirements but could also be a worthwhile business venture for GP partners or others looking to invest in building the capacity of rural communities.

Providing adequate and affordable childcare services is central to addressing the recurring theme around flexibility. Medical workforce data indicates that expected retirements from rural practices over the next decade will result in the employment of new GP recruits with increasing representation by females (McEwin, 2003). The females in this study have identified themselves as the main carers of their children. As there is no evidence to indicate that this situation will change in the future, childcare remains a critical and essential service for female GPs who want to optimise their participation in rural practice.

Financial incentives

In Table 31 various incentive payments are described that are available to rural GPs. As is the case with many large-scale programs there are eligibility requirements to keep the costs at a sustainable level. The part time status of female GPs and their positions in the practice meant that they were often ineligible to receive grants and payments provided through large-scale programs.

The female GPs in this study identified areas of financial inequity that were a result of the demands of their multiple roles as women, and the lack of recognition of the particular way they practiced medicine. More than half of the rural female GPs worked part time and had incomes commensurate with their part time status. They commonly reported that the longer consultations regularly provided by female GPs, resulted in their decreased contribution to the practice income. This often resulted in reduced or no access to Commonwealth funding under some of the practice incentive schemes, and further reduced their earning capacity. At the same time they also had indemnity insurance payments, and additional costs of childcare as a result of their work commitments and these were not adequately covered by their incomes.

Financial imperatives were a component of some of the other recruitment and retention issues identified by the females in this study. The affordability of childcare and locum cover were two areas where resolution would effect an increase in the working capacity of female GPs in a number of domains. This would allow them to increase their work hours, including the difficult area of after hours and on call work. They could also fulfil their mandatory training requirements and further skills acquisition, and access normal and emergency leave as part of their responsibility to their own wellbeing and to the needs of their families. As previously identified, flexibility is an essential component of this issue for female GPs, and its resolution involves a variety of stakeholders. The costs of childcare will depend on the source, but as shown by the Camperdown experience the cooperative participation by a range of stakeholders resulted in shared expense for the outlay and overheads that made it affordable. Locum cover comes at a cost, and is subsidised by governments to some extent, beyond which it is not a viable option for female GPs who may already be on a reduced income.

Addressing the financial issues raised by female GPs will require consideration of their specific concerns around expenses that are not covered by general funding initiatives. The part time status of female GPs that is largely a result of their other roles as women, is a disadvantage in terms of their earning capacity. The female GPs in this study were not asking to be paid for work they didn't do but rather to be supported to fulfil the multiple roles they had and for the additional expenses they incurred as a consequence of those roles.

Flexible Access to Training/CME

The training options detailed in Table 31 show that the elements are already in place to modify existing training programs or to introduce new programs to meet the training needs of rural female GPs. The females have identified the barriers preventing their access to training programs around timing, location and childcare. They have nominated additional training needs to meet the skill requirements of rural medical practice and to provide them with the personal skills to negotiate their workplace conditions and to take on leadership roles.

Some of the females' suggestions for flexible training options included the development of training modules that could be completed at a time and place that suited them. Providing a satellite dish at the GP's residence and timing tutorial broadcasts to fit in with a working woman with children was another suggestion. Some of the RWAs have installed satellite dishes for their GPs. Additional flexibility would be introduced by the provision of computer hardware with sufficient power and memory to download tutorial material and images, and access to the Internet at the female GP's residence. This would benefit the whole family by providing recreation and education opportunities, especially in remote areas. The down side of this level of flexibility is the loss of face to face networking opportunities and these should be considered in structuring any remote training options.

Local stakeholders including community groups, local businesses and philanthropic individuals in the community have a role to play in resolving the training requirements of female GPs as part of a recruitment and retention package. Their involvement could take the form of donations of hardware, providing additional space or sharing existing infrastructure. The work of Cheney *et al* (2003) on support mechanisms for rural medical families confirmed that any community based incentives that are proposed to support the female GP and her family, should have benefits for the community in order to receive its ongoing support. Indeed some of the community generosity and 'identity' that has been directed at small hospitals in the past might well be redirected to the general practice entity in the town. In this way the community is seen to support the encumbent GP, and any future recruit will understand that community support is part of the practice package.

Local stakeholders could benefit from a sponsorship drive to involve the big broadband providers, or some lesser-known providers, in the provision of infrastructure. This would not only give female GPs the access to training and diagnostic information on the internet, but wider application of the technology could introduce the whole community to the internet café society and its benefits. These providers could well hold a favourable view to the branding of their names on a worthy cause for the good publicity it affords.

The main issue for the females was their inability to access training and to fulfil their family and practice commitments. The theme of flexibility looms large in the provision of accessible training options for female GPs. The above discussion has focused on practical approaches to resolving some of the flexibility issues but the challenge for training organisations to increase the flexibility of their programs, remains.

Attitudes to female medical practitioners

In this matter the female GPs were seeking recognition and acknowledgement of the part they played in providing medical care to their patients. Some females were in a practice situation where they received the full support of their colleagues and were able to participate as their other commitments allowed, without disadvantage. Others described their colleagues' attitudes towards them as disrespectful of them as female GPs and felt they were not valued for their contribution to the practice.

The female GPs did not rate this issue as a high priority for change but considered it an area where they could effect some change themselves by becoming trained in leadership, negotiation and assertiveness. It is in these areas where the females can be supported by their professional organisations, and are already to some extent, as in the provision of training, advice in negotiation of work conditions and opportunity to participate in policy decisions that affect the profession as a whole. The tendency for female GPs to lack awareness of training and support programs has been identified in earlier studies (Strasser *et al*, 1997). The GP support organisations can enhance their support for female GPs by assisting them to increase their awareness and involvement as a way of bringing about changes in attitude towards them as females.

Locum provision and funding

On the basis of their responses to the survey the main impediment to female GPs accessing locum cover seemed to be the cost. There is no doubt that when GPs within the practice cover for the leave of a colleague the cost to the practice is minimal. The northern NSW practice cited above has a holiday roster that all the GPs can access because the practice model provides for this inevitability. By reviewing their practice model other multiple GP practices could be in a position to provide cover for each other without the cost of securing a locum. This is not an option in a solo practice or in a town with a few GPs, and it may not be possible when an unexpected emergency arises. In these cases, and when areas do not readily attract GPs, locum cover may be the only option.

There is currently a shortage of locums in some states even though the RWAs employ full time locums on salary and who are fully occupied for the period of their retention. However, the future of this program is in doubt due to the high cost of medical indemnity insurance. The OTD program is another source of locums and is utilised to a greater or lesser extent depending on the operational policy of the RWA in each state. The difficulties of providing cover through the locum program require further creative approaches similar to the Other Locum Doctors program run by NSW RDN. This program is also facing viability problems as a result of the medical indemnity costs. Rural DGP receive funding to assist in the provision of locums. This program is similarly affected by the shortage of locums and RWAs provide ongoing support to maintain the viability of the program.

Rural exposure and attitude

The female GPs who identified previous rural exposure as a benefit to females who came to rural practice by choice or who found themselves there because it was their partners' choice, believed that those females would be better equipped to rural life and practice from the experience. Recent initiatives that focus on the recruitment of students from a rural background have not been evaluated for their success as yet but there has been a measurable increase in the enrolment of rural students in some programs.

With the overall enrolment of female medical students in excess of 50%, it is possible that the rural female student numbers may have also increased. The range of undergraduate initiatives that are now in place are addressing some of the issues raised by the females in this study who would not have had access to them during their medical training. Data on the participation of females in rural student programs would identify whether there is a need to target females specifically. As their participation in other programs is not at the same level as males it is likely that they would require some encouragement to take up these places.

Safety and security

The only safety strategy identified to date is a 4WD driver's training program for remote GPs in the NT. Additional orientation is provided around Indigenous culture and language and while not strictly a safety issue, it would benefit female GPs to have an understanding of the culture of Indigenous patients to avoid unnecessary confrontation with patients or their families. The female GPs in this study rated safety as a high priority when it was included among 14 indicators of job satisfaction, but did not give it a high rating when responding to the open-ended questions about major issues and the changes that they thought would improve recruitment and retention. In discussions with individual female GPs it is clear that they expect problems in isolated or after hours situations and often take precautions to avoid trouble. However, they were not equipped to manage unexpected attacks and stalking. The development of guidelines and some training to recognise potentially unsafe situations and their management by GP support agencies and training organisations, would be invaluable to all female medical practitioners.

Conclusion

The Australian RWAs have contributed to this study in the belief that there is a need for programs that encourage females to enter the rural medical workforce. The workforce planning exercises carried out by the RWAs and the indications from other medical workforce data sources, such as the AIHW and AMWAC, show that the female to male GP ratio is increasing at a rate that requires a committed response to female GP issues in rural and remote Australia.

In this study female GPs have provided data about their life and work status, shared their experiences as females working in rural Australia, and voiced their opinions about changes to the current arrangements that could result in increased recruitment and retention of females to rural practice. In so doing they have contributed to the first national database of rural female GPs. Their experiences have given context to the way GP support organisations and other key stakeholders can consider how to move forward in developing strategies that have relevance to female GPs.

Current recruitment and retention strategies were showcased in Chapter 6 and their relevance to female GPs was examined in Chapter 7 of this report. Generic programs are readily accessible to female and male GPs, although there is some evidence to suggest that females are not as aware of these programs as their male counterparts. The female GPs have identified the gaps in areas where they need specific program support to accommodate the competing demands of work and family. Essentially it is proposed that these programs would be designed to meet the needs of female GPs, and if a male GP finds himself trying to meet the same competing demands as his female counterparts he would be able to access to these programs.

Having a national database and the ability to prioritise the survey findings according to the ranking ascribed by the females, provides a legitimate base for proposing and developing recruitment and retention strategies with the potential to address genuine issues. On this premise the discussion of strategies in Chapter 7 concentrated on suggestions made by individual female GPs and the findings of the Tolhurst and Lippert (2001) report. Female specific programs that are already in operation, and the possibility of expanding or enhancing existing generic strategies to make them more relevant to female GPs, were also discussed.

It is hoped that the information contained in this report will serve as a catalogue of current activity, and of shortfalls in support programs, as they relate to rural female GPs. Individuals, representatives of professional medical organisations and other key stakeholders have the opportunity to consider how and where they fit in addressing the issues raised in this report. Recurring themes emerging from this and other recent studies, around the current needs of rural female GPs and the future needs of female and male recruits, provide the basis for future planning and allocation of resources to their best advantage.

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Appendix A

Rural Female General Practitioner Survey

First Name: _____ Last Name: _____

Email: _____

Address: _____

_____ Post code ☐ ☐ ☐ ☐

1) Are you a member of a Division of General Practice?

☐ Yes ☐ No

If yes which Division? _____

2) Are you affiliated with a college?

☐ Yes ☐ No

If yes, which college?

☐ RACGP

☐ ACRRM

☐ RACGP & ACRRM

☐ Other please specify _____

3) Your age: _____

4) Marital status:

☐ Single

☐ Married/Defacto/Same Sex

☐ Separated/Divorced/Widowed

Partner's occupation _____

5) Do you have any children?

☐ Yes ☐ No

If "yes", what are their ages? _____

6) Do you carry the main responsibility for the care and rearing of the children?

☐ Yes

☐ No

☐ Shared with Spouse

☐ N/A (Eg, children are independent)

If "No", who has the main responsibility?

_____

7) How many of the children are still dependent on you?

_____

8) What year did you graduate? 1 9 ☐ ☐

9) Have you practiced in a metropolitan area prior to rural practice?

☐ Yes ☐ No

10) How long have you been in rural practice?

Years _____ Months _____

11) Were you raised in a rural environment?

☐ Yes ☐ No

If yes, where? _____

12) Reason(s) for choosing rural practice?

_____

_____

_____

_____

13) Is this your first rural practice location?

☐ Yes ☐ No

14) How many hours on average are you working each week?

Clinical Hours (excluding on call hours):_____ per week

On call hours: _____ per week

Other Hours: _____ per week

(Please specify the type of work during your other hours)

15) (a) Are you employed:

☐ Full time

☐ Part time

(b) Do you consider your current hours to be:

☐ Full time

☐ Part time

16) If you are working part-time are you doing so for family reasons?

☐ Yes

☐ No

☐ N/A

17) How would you describe your working hours?

☐ Would prefer to work fewer hours

☐ Would prefer to work more hours

☐ Satisfied with current working hours

18) If you are not satisfied with your current working hours what is preventing you from working your ideal working hours?

_____

_____

_____

_____

_____

19) Are you working in a town with a hospital?

☐ Yes ☐ No

20) Do you do hospital work?

☐ Yes

☐ No

☐ N/A

If yes, what hospital work do you do?

_____

21) What position do you hold in your current practice?

☐ Associate

☐ Salaried

☐ Locum

☐ Partner

☐ Solo

☐ Other Please specify _____

22) Do you intend to become a partner in a practice at some stage?

☐ Yes ☐ No

23) In the next five years are you planning to leave your rural practice?

☐ Yes

☐ No

☐ Undecided

If "yes" or "undecided", please elaborate:

Reason(s) for "yes"

_____

_____

_____

_____

_____

Reason(s) for "undecided"

_____

_____

_____

_____

_____

24) In the next five years are you planning to change the nature of your work?

☐ Yes

☐ No

☐ Undecided

If "yes" or "undecided", please elaborate:

Reason(s) for "yes"

_____

_____

_____

_____

Reason(s) for "undecided"

_____

_____

_____

_____

25) Please indicate the level of importance you attribute to the following areas with respect to job satisfaction and retention on a scale of 1 to 7 ("1" being not important at all and "7" being very important):

- ☐ (a) Child care arrangements for CME events.
- ☐ (b) Transparent (contracted) working arrangements.
- ☐ (c) More flexible practice opportunities including salaried and part-time positions.
- ☐ (d) Maternity leave policies.
- ☐ (e) Support networks for female medical practitioners.
- ☐ (f) Part-time registrar positions.
- ☐ (g) Support and assistance for workforce re-entry.
- ☐ (h) Safety provisions for after hours services.
- ☐ (i) Child-care provisions at local hospital when "called in" in emergency situations.
- ☐ (j) Organising after-hours locum cover.
- ☐ (k) Finding locums for the women's health aspect of your practice.
- ☐ (l) Post-graduate training to be more flexible while minimising the need to travel.
- ☐ (m) Tax incentives for child-care costs incurred while scheduled for on-call duty.
- ☐ (n) Access to health services for yourself.

26) Please indicate how much you would like to attend CME events on the following topics, and indicate how much of a scale 1 to 7 ("1" being not much and "7" being very much)

- ☐ a) Training in self-care/health.
- ☐ b) Dealing with role conflict.
- ☐ c) Methods of dealing with threatening, difficult and dangerous situations.
- ☐ d) Improving management/leadership and negotiating skills.

27) What other CME events would you like to attend? Please specify below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

28) **What do you see as the major issues affecting female medical** practitioners working in rural areas?

29) **What changes do you feel are needed in order to recruit and retain female medical practitioners in rural and remote (name of the state or territory)?**

Thank you for your participation!!!

Please place completed survey in accompanying self-addressed

Return envelope by:

Day & date

Appendix B

Modifications made to the rural female GP data before importing it to SPSS 11.5 for analysis

Modifications were required to standardise the data where individual States and the NT had made changes to the original NSW RDN survey questions. Details of the modifications made to the data before they were transferred from Microsoft Excel or Access to SPSS 11.5 are provided below with definitions of the categories used for analysis.

1	**Date of birth (DOB)**
	Surveys asked for date of birth, age, or age in years and months. All responses were converted to age at the time of the survey for SPSS.
2	**Rural, Remote, Metropolitan Areas (RRMA) Classification**
	The RRMA classification was inserted by the RWA or the author and based on each female GP's practice address.
3	**Division of General Practice (DGP) membership**
	Responses were confined to yes or no and names of the individual Divisions were not included for analysis in the national dataset.
4	**College affiliation**
	The RACGP and ACRRM were specifically identified as they were the most common affiliations and additional affiliations were recorded as 'Other'.
5	**Marital status**
	The three categories of 'Single', 'Married/defacto', and 'Separated/divorced/widowed' were used to separate the single women from those in a relationship, and same sex or any other relationship categories were included in married/defacto.
6	**Spouse occupation**
	The category name was changed to 'partners' occupations' and the types were based on the QRMSA categories of occupations. Some categories were modified to accommodate additional occupations in the other states.
7	**Children's ages**
	Some women had more than four children and were included in the dataset under the category 'more than four children'. This category was chosen because 98% of the women with children had between one and four. Maintaining the respondents' privacy was an important consideration in the choice of categories for this question.
8	**Main childcare responsibility**
	The options were reduced to yes, no and shared (with partner was understood).
9	**Rural origin**
	Individual Australian locations were not considered to be relevant for the national dataset and rural origin options were limited to Australia and overseas.
10	**Reason for rural practice**
	Fourteen options were provided to include all possible responses where an individual female GP gave more than one reason. Responses were recorded as positive or null for each option.
11	**Work hours**
	Categories were confined to clinical, on call and other, and details of the types of other work are described in the Results section.

12 Part time or full time status

In Queensland and WA female GPs were asked how many hours of each type (clinical, on call and other hours) they considered were part time or full time. On the basis of their responses to this question, the number of hours they worked each week was used to assess their part time or full time status. In NSW, Victoria, SA and NT the women were asked directly if they worked full time or part time. In Tasmania part time was recorded as less than 40 hours per week. The status recorded by researchers in each state and territory was used for the national database, and where it was not clearly defined, part time status was applied to females who worked less than 35 clinical hours per week.

13 Barriers to preferred working hours

Seven options were provided to include all possible responses where an individual female GP gave more than one reason. Responses were recorded as positive or null for each option.

14 Job satisfaction

The rating scale was set at 1 to 7 (where 1 is least important and 7 is most important) or 1 to 10 (where 1 is least important and 10 is most important) depending on the state or territory. All responses were standardised to a scale of 1 to 7.

15 Continuing Medical Education (CME)

The rating scale was set at 1 to 4 (where 1 is least important and 4 is most important) or the 'order of preference' (from 1 to 4) depending on the state or territory. Some respondents also continued using the 1 to 7 or 1 to 10 scale from the previous question. All responses were standardised to a scale of 1 to 4.

16 Major issues for rural female GPs

The issues were categorised using the model from the QRMSA report with some adaptations to accommodate additional issues from the other states.

17 Changes to increase recruitment and retention of female GPs

The same as for Major Issues.