THE AUSTRALIAN COLLEGE
OF RURAL & REMOTE MEDICINE

support for

women doctors

in rural and remote Australia

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AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE

SUPPORT FOR WOMEN DOCTORS IN RURAL AND REMOTE AUSTRALIA

ACRRM RESEARCH PROGRAM

MAY-SEPTEMBER 2003

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Rationale

ACRRM is currently engaged in a program to review the current status of women doctors in rural and remote practice in terms of what they identify as the principal factors in influencing their professional, family and community life and what might constitute barriers and deficits to doctors achieving their preferred goals. This report will begin the process of documenting the priorities for action, engaging in consultation to develop potential solutions and confirming the agenda ACRRM should be advocating on their behalf.

Rural communities need doctors of both genders in the development of a full range of services and in the provision of appropriate access to care that meets the preferences of community members. Women doctors also, need a renewable cohort of colleagues, both male and female that is interested in mentoring and supporting others through the challenges of professional and family life in a rural town.

The importance of generating a strategic approach to the support of the female medical workforce becomes evident when data on the relative numbers, age structure and distribution of women doctors is reviewed. The increasing proportions of female to male medical students and the ongoing impact of these numbers now flowing on to junior doctor and registrar ranks, provides an additional imperative to ensure that key differences in the emerging roles of male and female doctors are understood at each level.

Principal issues

The major issues impacting on the practice of ACRRM women doctors have been identified by:

- The analysis of policy and strategic material developed by expert groups, including the ACRRM Women in Rural Practice (WIRP) group
- Refinement of a basic typology by reference to the literature.

The resulting 60 issues formed the basis for the member survey under the following categories:

- Policy and national issues affecting women doctors
- Practice in the rural community
- Education and training
- Support - resources and personnel
- Legal and financial issues
- Family and personal issues
- The future

Summary of results

A 76% return of surveys and qualitative comments provides the results with some degree of reliability. Analysis by age group, RRMA and State is also available. The top ranking issues across all respondents are as follows.

- Government categorisation / recognition of the different requirements of rural and remote practice
- Capacity for taking leave with the family
- Greater recognition by government of the implications of the feminisation of the medical workforce
- Adequate recognition within the practice for the counselling and long consultations provided by female doctors
- Item number recognition of longer consultations as a reflection of the pattern of practice of women doctors
- Indemnity and other insurance costs
- Availability of good education for children in rural towns
- Recognition by government and workforce planners of changing preferences for combining medical / social / family life
- Flexibility with on call scheduling
- Raising community support and awareness of implications of losing services
- Support for secondary education for children.

What emerges from the analysis of subsets of the membership is that, allowing for some specific variation stemming from remoteness, procedural load and stages of family life, there is a consistent prioritisation of the issues that lead to:

- Recognition for the professional domain of rural and remote medicine
- Recognition at the practice level of the particular contribution of female members of the practice
- Adequate and appropriate financial reward for specific consultation modes and patterns
- Flexibility in terms of professional schedules
- Development of career structures that allow time for family and community involvement as well as quality leave time
- Opportunities for professional development and upskilling that are accessible and appropriately supported.

Further action

ACRRM will be making these results widely available and advocating key issues to appropriate organisations and seeking opportunities to link with national processes of support for female doctors. A "Strategic Solutions Paper" will also be developed as an outcome of the consultation process. By these means, ACRRM intends to promote relevant and achievable program outcomes for the consideration of professional organisations, funding agencies and supporting bodies.

Through its WIRP group, ACRRM will consider strategies to respond to the priorities of its members and seek to engage a broader cross section of the female medical workforce in its activity.

The similarity between many of the issues raised, and the needs and aspirations of young male doctors have not been overlooked. Initiatives emerging from this activity will enlarge the capacity of the rural College to address the education and support requirements of current generalist and specialist registrars interested in a sustainable career and a good lifestyle in rural medicine for themselves and their families.

SUPPORT FOR WOMEN DOCTORS IN RURAL AND REMOTE AUSTRALIA

1. INTRODUCTION

It is evident from emerging medical workforce figures that an increasing proportion of doctors graduating from medical schools are women. Over time, these new graduates are entering junior doctor and registrar training and are indicating, to some extent, that previously accepted models of teaching, mentoring and working routine need to be reviewed and adapted to meet their particular requirements as professionals, family members, rural community members and individuals.

In addition, more senior female members of the medical profession have identified, and to some extent accommodated, the particular challenges of being jointly a doctor, a carer and a woman in rural and remote practice.

These members of the profession provide a unique resource in terms of identifying current barriers to the sustainability of female doctors in practice and in terms of providing insight to the types of support initiatives required to both sustain the existing female workforce and to ensure that new generations of women doctors are able to practice in rural communities with enjoyment and satisfaction.

Rural communities need doctors of both genders in the development of a full range of services and in the provision of appropriate access to care that meets the preferences of community members.

Women doctors also, need a cohort of colleagues both male and female that is interested in mentoring and supporting others through the challenges of professional and family life in a rural town.

ACRRM is currently engaged in a program to review the status of women doctors in rural and remote practice in terms of what they identify as the principal factors in influencing their professional, family and community life and what might constitute barriers and deficits to them achieving their preferred goals. This report will begin the process of documenting the priorities for action, engaging in consultation to develop potential solutions and confirming the agenda ACRRM should be advocating on their behalf.

ACRRM has therefore commissioned a survey of its women members as a first step in this national consultation process to develop a strategic framework for action.

2. ISSUES IN THE LITERATURE

2.1 Rural female medical workforce profile

The importance of generating a strategic approach to the support of the female medical workforce becomes evident when data on the relative numbers, age structure and distribution of women doctors are reviewed. The increasing proportions of female to male medical students and the ongoing impact of these numbers now flowing on to junior doctor and registrar ranks, provide an additional imperative to ensure that key differences in the emerging roles of male and female doctors are understood at each level.

It is clear that preferences for particular types of practice and role within the family are not solely determined by gender. Many of the issues that traditionally apply to the female professional and carer are now important options for male doctors and are increasingly identified by them as an important aspect of life. Young female and male doctors alike identify time with family and with children as very important and state a preference for roles in medical practice that are challenging, flexible and enjoyable. [1]

In view of the relative numbers of female and male doctors in training, the barriers to supporting female doctors in rural and remote practice must be better understood and strategies developed for specific support mechanisms and styles of both practice and training.

2.1.1 Gender distribution

Recent studies indicate that there are smaller numbers of female than male doctors practicing within rural and remote areas. This raises the issue of identifying the key barriers to practice for female doctors in rural areas and providing strategic solutions. A report by Tolhurst et al [2] stated that only 19% of the Australian rural general practice workforce was female and current ACRRM research [3] indicates the paucity of women rural generalists and proceduralists.

This trend has also been reflected in other studies conducted in NSW, [4] and Victoria. [5] Data collected in Queensland [6] also demonstrated this trend although indicating somewhat higher percentages of female doctors owing to local differences in the structure of health service delivery. These findings are anomalous to the overall make-up of the general practice workforce nationally and particularly of the proportions of females to males currently in general practice training.

Whilst in the minority at present, the number of female doctors is expected to increase dramatically over the next decade, with women currently comprising almost 58% of the

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[1] Australian College of Rural and Remote Medicine (ACRRM), National Evaluation of the Rural and Remote Area Placement Program, Report to the Commonwealth Department of Health and Ageing, February 2003.
[2] Tolhurst HM, Talbot JM, Baker LLT. Women in rural general practice: conflict and compromise. *Medical Journal of Australia 2000; **173**: 119-20.*
[3] ACRRM, Barriers to the maintenance of skills in procedural rural medicine, ACRRM, September 2002.
[4] Levitt L. Women in the Medical Workforce Review. *New South Wales Rural Doctors Network, 2000.*
[5] Wainer J. Female Rural Doctors in Victoria: It's where we live. *Rural Workforce Agency Victoria, Carlton: 2001.*
[6] White C, Fergusson S. Female Medical Practitioners in Rural and Remote Queensland: An analysis of findings, issues and trends. Discussion Paper, *Queensland Rural Medical Support Agency, Brisbane: 2001.*

cohort of registrars entering the Australian General Practice Training Program in 2004. This trend will have important ramifications for the rural medical workforce. [7]

2.1.2 Age distribution

Medical school selection policies over the last ten years are also impacting the balance of the medical workforce. Evidence suggests that the female rural medical workforce is considerably younger than its male counterpart and that the distribution of female doctors peaks during the most demanding stages of childrearing years.

A national study by AMWAC found that 53.4% of all rural general practitioners aged less than 35 years were female. [8] Additional studies undertaken at both the national level,[9] [10] and in NSW,[11] Victoria[12] and Queensland[13] also demonstrate increasing percentages of females aged less than 49 years working in rural and remote areas than formerly.

2.1.3 Geographic distribution

Despite conflicting opinion regarding its causes, inequities in the distribution and supply of doctors, particularly in rural and remote locations has been recognised by Government, [14] [15] and professional agencies [16] alike. These inequities are further pronounced when referenced to the distribution of female practitioners by the Rural, Remote and Metropolitan Areas (RRMA) classification.

Harding's comparison of female and male doctors in RRMAs 3 to 7 illustrates this trend, with only 18% of all women doctors working in these locations as compared to 25% of all males. [17] The discrepancy is maintained within most rural locations (RRMA 3 to 5) with the margin narrowing substantially for males (1.8%) and females (1.6%) working in remote areas. This pattern of distribution is evident nationally. [18] [19]

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[7] Australian Institute of Health and Welfare. Medical Labour Force 1998 (AIHW Cat. No. HWL15). *Canberra: Australian Institute of Health and Welfare, 2000.*
[8] Australian Medical Workforce Advisory Committee. The medical workforce in rural and remote Australia. *AMWAC Report: Sydney, 1996.*
[9] Strasser R, Kamien M, Hays R, Carson D. National Rural General Practice Study. *Monash University Centre for Rural Health: Traralgon, 1997.*
[10] Tolhurst H, Lippert N. The National Female Rural General Practitioners Research Project. *University of Newcastle: Newcastle, 2001.*
[11] McEwin K. Wanted: New rural workforce strategies for female doctors' findings from a survey of women in rural medicine. *New South Wales Rural Doctors Network: Sydney, 2001.*
[12] Wainer J. 2001, op. cit.
[13] White C, Fergusson S. 2001, op. cit.
[14] Harding J. The supply and distribution of general practitioners. *In General Practice in Australia: 2000. Office of the Medical Advisor, General Practice Branch, Health Services Division, Department of Health and Ageing: Canberra, 2000.*
[15] Strong K. Health in Rural and Remote Australia. *Australian Institute of Health and Welfare: Canberra, 1998.*
[16] AMA and RDAA. Increasing Rural Medical Services: Discussion Paper. *Australian Medical Association and Rural Doctors Association of Australia: Canberra, 1998.*
[17] Harding J. 2000, op. cit.
[18] Wainer J. 2001, op. cit.
[19] Levitt L. 2000, op. cit.

2.2 Practice characteristics

2.2.1 Time in practice

The preference of women practitioners for employment on a part time basis is acknowledged anecdotally in the literature, but not always evidenced in research findings. A national study undertaken by Tolhurst and Lippert found very little difference between the number of females working full and part time. White and Fergusson reported similar findings in a Queensland based project. More substantial differences were found in the two studies conducted in NSW and Victoria, where 61% and 63% of females reportedly worked on a sessional basis.[20] [21]

Variation in the definition of what constitutes full and part time employment as a doctor in general by workforce researchers has significant implications on how women doctors, rural or urban, perceive themselves and their contributions. This issue continues to influence the degree to which the rural workforce is understood in terms of its capacity to deliver sustainable services in real terms and to retain personnel.

Any preference for part time employment is better understood in terms of expressed satisfaction with current working hours. Studies demonstrating higher percentages of females in part time employment also reported higher levels of satisfaction with their hours of work. [22] In comparison, the Queensland study that reported little difference between full and part time numbers, demonstrated a lower level of satisfaction with working conditions citing 52.4% of female respondents who indicated a preference for fewer hours. [23] Patient workload was seen as the major barrier that prevented female doctors working their preferred hours.

2.2.2 Group and solo practice

The majority of rural female practitioners also demonstrated a strong preference for working within a group practice environment, with Tolhurst & Lippert reporting that 78% of respondents worked in a practice with at least three other practitioners. This is in keeping with the preference to work shorter hours and would tend to increase flexibility in this regard. A smaller but significant percentage (13-14%) of female doctors worked as solo practitioners. [24] [25]

2.3 Professional satisfaction

Evidence suggests that for female practitioners, the opportunity to practise in a rural or remote environment can provide a great deal of professional satisfaction. However, there are just as many factors that have the potential to negate this.

[20] McEwin K. 2001, op cit.
[21] Wainer J. 2001, op. cit.
[22] McEwin K. 2001, op. cit.
[23] White C, Fergusson S. 2001, op. cit.
[24] Tolhurst H, Lippert N. 2001, op. cit.
[25] Wainer J. 2001, op. cit.

2.3.1 Holistic care

The opportunity to deliver high quality, continuous and holistic care is a major drawcard for females in rural and remote practice. Around 25% of female doctors report that the ability to extend their practice work to include hospitals and the wider scope to utilise procedural skills are major benefits in undertaking rural practice. [26]

The broad range of health care and medical needs reported by rural and remote communities facing socio-economic decline and service closures further supports this extension of practice. [27] However, these service closures, particularly those provided by hospitals, can also significantly reduce the scope for practice and advanced procedural skills. In recent times, indemnity concerns have also been perceived as having a negative impact on procedural practice. [28]

2.3.2 Value and recognition of contribution

The benefits of acknowledgement and recognition of the work undertaken by rural women doctors by both the community [29] [30] and other professional colleagues [31] is well documented. However studies indicate that many female practitioners feel that their contributions are not held in the same regard as those of their male counterparts, owing to longer consultations[32] [33], shorter hours worked,[34] limited participation in the on call roster due to a lack of suitable child care, locum arrangements and personal safety concerns [35] and feminised practice content limitations. [36] This can result in rural female doctors feeling professionally isolated, unsupported and undervalued whilst placing them at a disadvantage in terms of appropriate remuneration.

2.4 Professional support and development

A range of suitable professional support and development mechanisms must be in place to encourage female practitioners to relocate and remain within rural practice.

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[26] ACRRM. September 2002, op.cit.
[27] Dunne P, Patterson C, Kilmartin M, Sladden M. Health service provision in rural and remote areas: a needs analysis. *Medical Journal of Australia 1994;**161(2)**: 160-2.*
[28] ACRRM. September 2002, op. cit.
[29] Tolhurst H, Lippert N. 2001, op. cit.
[30] Cutchin MP. Community and self: concepts for rural physician integration and retention. *Social Science and Medicine 1997; **44(11)**: 1661-74.*
[31] Chambers R, Campbell I. Gender differences in general practitioners at work. *British Journal of General Practice 1996;**46(406)**: 291-3.*
[32] Shanley BC, Schulte KM, Chant D, Jasper A, Wellard R. Factors influencing the career development of Australian general practitioners. *Australian Family Physician 2002; **31(1)** 49-54.*
[33] Brooks F. Women in general practice: responding to the sexual division of labour? *Social Science and Medicine 1998;**47(2)**: 181-93.*
[34] Spenny ML, Ellsbury KE. Perceptions of practice among rural family physicians – is there a gender difference? *Journal of the American Board of Family Practice 2000;**13(3)**: 183-7.*
[35] Cuddy NJ, Keane AM, Murphy AW. Rural general practitioners' experience of the provision of out of hours care: a qualitative study. *British Journal of General Practice 2001; **51(465)**: 286-90.*
[36] Brooks F. 1998, op. cit.

2.4.1 Access to education and training

The difficulties faced by rural and remote doctors in accessing appropriate education and professional development courses are well documented. Lack of appropriate local or regional training facilities, travel involved in accessing training outside their immediate practice area, [37] [38] [39] time constraints and the inability to get suitable locum coverage whilst attending training [40] have been identified as major impediments. Insufficient child care arrangements both within the community and at Continuing Medical Education training events [41] further prevent female access to professional development.

This can result in an increased sense of professional isolation and lack of support through limited networking opportunities, especially with other women doctors. [42] The associated costs of attending professional development courses, including locum coverage and appropriate childcare if available, place rural women doctors at a further economic disadvantage.

2.4.2 Non–Clinical professional development

Whilst clinical CME topics are considered important, many women doctors working within rural and remote locations identify that non–clinical professional development opportunities are highly desirable. Opportunities relating to business management, leadership development, and conflict resolution and negotiation skills are particularly emphasised in order to better equip women doctors in supporting themselves as well as other rural females in a range of professional and personal situations. [43]

2.4.3 Rural and remote practice incentives and initiatives

Evidence suggests that whilst there are a number of rural practice incentives and initiatives by government [44] and professional support agencies, [45] most rural women doctors have little awareness of these and their eligibility to access them. Whilst these initiatives would go some way toward improving recruitment and retention of general practitioners in rural locations, most women doctors felt the incentives did not fully recognise or address their particular concerns. [46]

This is particularly important in terms of professional support agencies, which may lose significant proportions of female membership due to this perceived lack of acknowledgement or advocacy.

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[37] ACRRM September 2002 op. cit.
[38] Cameron I. Women in rural general practice: conflict and compromise. *Medical Journal of Australia 2000; **173**: 119-20.*
[39] Wainer J. 2001, op. cit.
[40] White C, Fergusson S. 2001, op. cit.
[41] Tolhurst HM, Talbot JM, Baker LTT. Women in rural general practice: conflict and compromise. *Medical Journal of Australia 2000; **173**: 119-20.*
[42] Wainer J. 2001, op. cit.
[43] Wainer J. 2001, op. cit.
[44] Cameron I. 2000, op. cit.
[45] McEwin K. 2001, op. cit.
[46] Tolhurst H, Lippert N. 2001, op. cit.

2.4.4 Essential resources and partnerships

The need for resources and strong working partnerships is essential within rural and remote practice. Access and support to a range of local and regional services such as hospitals, community health and within the community itself are mandatory if rural doctors are to meet the health care needs of the community. [47]

However, the closure and relocation of hospital and other health services can impact on the delivery of care to the community, whilst creating additional pressure on the rural doctor. [48] [49] Hays et al also recognised the importance of personality conflict within professional working relationships, from both within individual practices and external health care providers. [50]

2.5 Family and lifestyle

Most women doctors working within rural or remote areas are involved in some form of committed relationship, with several studies reporting between 86-93% of females were married or in partnership relationships. [51] A slightly smaller percentage of women reported having children (72-87%),[52] with studies in NSW and Victoria reporting an even spread across children's age categories with the exception of Queensland where the majority of children were at or under primary school age. [53] These factors have been reported to have significant influence on the decision making of rural women doctors.

2.5.1 Rural lifestyle

The attractiveness of rural life has been identified as a major consideration in deciding to practice and remain in either a rural or remote location, with 54% and 47% of women doctors in Victoria and NSW respectively indicating this as their motivation for being in rural practice. [54]

The physical environment, sense of community and better education and developmental opportunities for primary school aged children were the main factors identified but with rural communities in reported decline, a number of potential trigger factors have been identified that could pre-empt the decision to leave rural practice.

2.5.2 Partner issues

Employment and education opportunities for the partners of women doctors have been identified as a major trigger in deciding to practice and remain in a rural location. [55] [56] Whilst many partners of women doctors are themselves involved in the medical or

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[47] Cameron I. 1998, op. cit.
[48] ACRRM. September 2002 op. cit.
[49] Dunne P, Patterson C, Kilmartin M, Sladden M. 1994, op. cit.
[50] Hays RB, Veitch PC, Cheers B, Crossland L. Why doctors leave rural practice. *Australian Journal of Rural Health 1997; **5**: 198-203.*
[51] Tolhurst H, Lippert N. 2001, op. cit.
[52] Tolhurst H, Lippert N. 2001, op. cit.
[53] White C, Fergusson S. 2001, op. cit.
[54] Wainer J. 2001, op. cit.
[55] Shanley BC, Schulte KM, Chant D, Jasper A, Wellard R. 2002, op. cit.
[56] WACRRM. Female General Practitioners in Remote and Rural Western Australia, WACRRM 2002.

health care fields, a lack of employment opportunities can lead to increased financial pressures, social isolation and lack of support. Some partners are prepared to take on the primary caregiver role, but due to the potential effects on their own careers, this is only a short-term option.[57] Rural community attitudes towards male partners taking on this care provider role particularly towards young males with children can further increase their sense of social isolation and lack of support.

2.5.3 Rural community decline

Community infrastructure and the levels of perceived support from the community are also decisive when determining whether to remain in rural practice. [58] As rural communities face greater declines in the availability of important local services such as health services, childcare and schools, there is an increased possibility that female practitioners will choose to relocate to centres with more viable infrastructure to meet their family needs.[59] This is especially relevant in regard to those women doctors with children entering secondary studies. This decline in services also has a significant impact on a community's ability to attract, support and retain relevant health care and other service professionals.

2.5.4 Personal issues

Personal health and well being, a lack of privacy and social isolation issues have also been identified as major concerns for women doctors working within rural and remote environments. [60] [61]

2.5.5 Utilisation of family and personal support services

Evidence suggests that women doctors are largely unaware of family support services in their local or regional area. White and Fergusson reported that 68% of rural female practitioners were unaware that such services existed and this is reflected in the relatively low utilisation rate (7.1%). [62]

2.6 Intention to remain in rural practice

It appears that the majority of women doctors intend to remain in their current practice location. Several studies have reported that between 48-66% of these women intend to continue in their current practice for at least 5 years. [63] Almost double the numbers of women doctors in Queensland were intending to leave rural practice within the next five years (30%) [64] as compared to those in Victoria (13%) [65] and New South Wales (16%). [66] All three studies reported similar percentages of practitioners who were yet to make a decision.

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[57] Tolhurst H, Lippert N. 2001, op. cit.
[58] Hays RB, Veitch PC, Cheers B, Crossland L. op. cit.
[59] White C, Fergusson S. 2001, op. cit.
[60] Wainer J. 2001, op. cit.
[61] Tolhurst HM, Talbot JM, Baker LTT. 2000, op. cit.
[62] White C, Fergusson S. 2001, op. cit.
[63] Wainer J. 2001, op. cit.
[64] White C, Fergusson S. 2001, op. cit.
[65] Wainer J. 2001, op. cit.
[66] McEwin K. 2001, op. cit.

Available literature suggests that the decision to leave rural and remote practice is linked to the impact of trigger factors on the balance of tensions between the professional and private realms. [67] The development of strategies to assist women doctors to better balance these tensions would significantly reduce the potential of trigger factors and thus do much to encourage females to remain within rural and remote practice. This on its own is not enough however, as equal importance and consideration must also be given to the reasons why women doctors chose to practice in a rural and remote location initially.

2.7 Conclusions

The evidence suggests that if women doctors are to be encouraged to practice in rural and remote locations, effective strategies that seek to achieve balance within their professional and personal responsibilities must be implemented, particularly given the increasing number of females now entering medicine.

With the literature indicating that women doctors are likely to put their family ahead of any professional concerns, there is a need for the greater promotion of the family and personal support services available to doctors within their immediate area. It should also be recognised that many of these issues are also rated as priorities by young male doctors.

Rural communities trying to attract women doctors need to be better informed of the particular family concerns and how to best support or accommodate these. This is particularly important in regard to partner employment, education opportunities for children and social isolation for both female practitioners and their partners.

To further encourage females into rural practice, consideration must also be given to the professional environment in which women doctors are expected to function. The development of sustainable practice arrangements that have the flexibility to incorporate family demands will do much to increase the attractiveness of rural practice to women doctors whilst also improving levels of professional satisfaction. Flexibility in work hours, appropriate remuneration and entitlements, and access to appropriate childcare and locum services would serve as further incentives to practice in a rural or remote location.

Whilst access to CME and other forms of professional development and support have improved over the past decade, there are still many barriers to be overcome. There is a need for greater flexibility in the provision of professional development activities and increased local and regional area education opportunities.

The provision of appropriate childcare and locum services would greatly assist rural women doctors to attend relevant educational events and provide opportunities to network with other females in rural practice. Expansion of CME sessions to address non-clinical topics such as leadership and conflict resolution and better representation and advocacy by professional support agencies would also reduce the sense of professional isolation experienced by many women doctors working within rural and remote environments.

[67] Hays RB, Veitch PC, Cheers B, Crossland L. 1997, op. cit.

3. METHODOLOGY

3.1 Summary and timeline

The strategies proposed for the initial research methodology were selected to develop an evidence-based approach that is achievable with a relatively small cohort and within a short timeline.

- Development of a literature review to establish a typology of influencing categories and referencing of the major issues under key headings
- Development of a national sampling framework of 298 female doctors in RRMA 1-7 who are members of ACRRM
- Administration of the survey identifying and defining key categories and issues for prioritization
- Supporting interviews and consultation arrangements with respondents and with rural organisations
- Analysis and reporting of findings to a broader rural medical group as the basis for developing strategies towards solutions on the issues raised and recommendations for action.

3.2 Sampling framework

The sampling framework included all female medical members of ACRRM in RRMAs 1-7. Data was analysed by state, RRMA and age group for the 298 female members surveyed. This enabled a study of both issues clearly referring to doctors in rural and remote areas and to those that apply to metropolitan and provincial towns.

The proportions of doctors surveyed from each state are as follows:

Queensland 23.5%, New South Wales 28.2%, Tasmania 3.0%, Australian Capital Territory 1.0%, Northern Territory 3.7%, Western Australia 8.1%, South Australia 13.4% and Victoria 19.1%.

The sample contains the following proportions within RRMA classifications:

RRMA code 1 – 17.8%, RRMA code 2 – 1.7%, RRMA code 3 – 4.4%, RRMA code 4 – 18.4%, RRMA code 5 – 44.0%, RRMA code 6 – 7.7% and RRMA code 7 – 6.0%.

Age group distribution within the sample is: 21-30 years – 2.4%, 31-40 years –28.5%, 41-50 years – 49.7%, 51-60 years – 15.7%, 61-70 years – 3.0% and 71 years and over 0.7%.

3.3 Guiding typology

Based on a preliminary consultation with rural medical organisations and with an analysis of all policy document and strategic directions emanating from the ACRRM WIRP group, a typology of issues was developed to guide both the issues developed in the literature review and the component parts of the survey (Attachment One).

These data are intended to:

- Provide an indicative basis for an action agenda by ACRRM and other rural medical organisations; and
- Identify trends to Government that might form the basis for further investigation.

3.4 Identification of issues

The major issues impacting on the practice of women rural and remote doctors have been identified in two ways:

- The analysis of policy and strategic material developed by expert groups, including the ACRRM WIRP group
- Refinement of a basic typology by reference to the literature.

The result is the following categorisation of issues that formed the basis for the member survey. Issues were placed randomly within each category.

3.5 Potential influences on the practice of female doctors in rural and remote medicine

3.5.1 Policy and national issues affecting female doctors

- A need for specific policy initiatives for female doctors
- A need for a national network to support female doctors and their issues
- A need for changes in national attitudes with regard to the value placed on female doctors' contributions
- Greater recognition by Government of the implications of the feminisation of the medical workforce
- Government categorisation/ recognition of the different requirements of rural and remote medical practice
- Current Government policies on health care delivery that influence your practice
- Regulatory/ recognition issues between Colleges
- The level of rural focus of professional organisations
- Current trends towards centralisation of services

3.5.2 Practice in the rural community

- Importance of communities targeting the recruitment of female doctors
- Special orientation for female doctors on entering rural practice
- Raising community support and awareness of implications of losing services
- Supporting your ability as a doctor to respond to community needs
- Pressures owing to community preference for the same gender doctor
- Imposed specialisation – women's health

- Adequate recognition within the practice for the counselling and long consultations provided by female doctors
- Safety issues with after hours and on-call
- Maternity leave policies at your practice
- Flexibility of practice arrangements especially when children are young
- The capacity to job share
- Flexibility with on-call scheduling
- Case numbers available locally to ensure currency in your areas of interest
- Levels of colleague or locum support when required
- Opportunities for compatible employment for spouse
- Capacity for taking leave with the family
- Perceived competition, professional domain and territorial issues

3.5.3 Education and training

- Ensuring that medical training at each stage recognises the types of practice and principal issues of female doctors
- More positive and routine rural female doctor input to medical training and teaching
- Current lack of suitable forms of teaching and training for your requirements
- Lack of appropriate recognition/ reward for teachers and mentors
- Ability to take leave for training – time constraints, professional limitations
- Access to training/ retraining to suit patterns of consultation
- Availability of part-time registrar/ general training options
- More flexible options for postgraduate and professional training
- Local/ regional skills maintenance and upskilling at reasonable cost
- Retraining opportunities in procedural work
- Pressures of maintaining a broad range of skills
- Retraining grants including cover for the cost of childcare

3.5.4 Support - resources and personnel

- Specifically skilled locum provision for your type of practice
- Access to specialists – resident/ visiting for appropriate training and backup
- Partnering – levels of access to colleagues with complimentary skills
- Access to auxiliary health personnel
- Provision of greater/ more available support networks and mentors for female doctors

3.5.5 Legal and financial issues

- Changing patterns of litigation
- Indemnity and other insurance costs
- Incentives that reflect the type of practice routinely done by female doctors to attract more females to rural practice
- Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors
- Costs of professional memberships
- Costs of upskilling versus income recovery
- Additional tax incentives to cover professional expenses/ childcare

3.5.6 Family and personal issues

- Recognition by Government and workforce planners of changing preferences for combining medical/social/ family life
- Support for the families of female doctors built into recruitment strategies
- Greater promotion of female doctors into leadership and decision-making
- Living and working in the same community
- Challenges in maintaining your own health
- Provision or assistance with childcare and domestic responsibilities
- Availability of good education for children in rural towns
- Support for secondary education for children

3.5.7 The future

- Providing new models of training to respond to the feminisation of the workforce
- Providing new models of training/ skills maintenance for part time doctors

3.6 Survey administration and analysis

Survey administration took place in June and July 2003 and generated a 76.0% from members comprising a 73.5% of completed surveys and a further 2.5% of member comments minus surveys. Analysis of aggregate results, differentiation by State, RRMA and age group has been undertaken using standard SPSS analysis.

It is recognised that there is no basis at this time to assume that the views of ACRRM female members represent those of women doctors in general, however a review and consultation round, based on the survey results is designed to test the generalisability of findings and to generate solutions to issues raised. The research is therefore not an indicative study, however the methodology has been rigorous and the project is timely in view of the national debate currently in progress around strategies for support of the female rural medical workforce and means to encourage more young women doctors to consider the option of a rural career.

4. RESULTS

4.1 Introduction

It is evident that the female medical members of ACRRM have clear priorities for activity by the rural College and have provided a strong response to the survey. At the close of analysis a response of 76.0% of members was recorded with 73.5% of totally completed questionnaires counted in the analysis. This response rate provides a sound evidence base on which to develop the ACRRM agenda in support of our female members.

The results also raise a number of issues that are of significance to the rural and remote medical profession in terms of its capacity to sustain challenging and rewarding career paths and professional arrangements for medical families, not only for female doctors.

Participants were asked to rate the importance of a list of 60 issues to their professional, family and community life and to identify the issues as of significant, moderate or lesser importance at this time. The relative nature of this assessment must be stressed. Each of the issues figures in the literature as having some determining effect on the capacity of doctors to practice and live well in rural and remote areas. Therefore the rating is more of a prioritisation by ACRRM members than a judgement on whether issues are relevant or irrelevant. To simplify responses, the issues are grouped under the following headings:

- Policy and national issues affecting women doctors
- Practice in the rural community
- Education and training
- Support - resources and personnel
- Legal and financial issues
- Family and personal issues
- The future

An indicative sample of the highest and lowest rating results is provided here. Complete rankings are available and will be included in Supplement form as required.

4.2 Demographics

Respondents to the survey fall into the following categories:

Table One: Demographics

	Frequency	Percent
QLD	48	21.9
NSW	56	25.6
VIC	45	20.6
SA	29	13.2
NT	11	5.0
WA	17	7.8
TAS	9	4.1
ACT	4	1.8
Total	219	100.0

Of these respondents, 45.8% practice in RRMA 5, 18.2% in RRMA 4, 15 % in RRMA 1 and 2, 9.4% in RRMA 6 and 6.9% in RRMA 7. Also, for purposes of analysis we have divided the

cohort into groups of 40 years and under (32%) and 41 years and above (68%) to examine variations in priorities for doctors more likely to have younger children.

4.3 Aggregate results

In terms of the aggregate results of priorities of the ACRRM membership all issues were ranked and full data sets are available on each category. However for reporting purposes the lists in Tables Two and Three below indicate the top priorities of respondents in all RRMA codes and the issues that were of lowest priority for the membership at this time. It is fair to say that lowest priority should be viewed as a relative term, as the issues listed in the survey are a collection of items that have emerged from research studies nationally and are all important. These results indicate priorities for strategic planning and solutions development.

Table Two: High priority issues

Category ranked as of highest significance	Percentage
Government categorisation / recognition of the different requirements of rural and remote practice	81.1%
Capacity for taking leave with the family	76.0%
Greater recognition by Government of the implications of the feminisation of the medical workforce	75.5%
Adequate recognition within the practice for the counselling and long consultations provided by female doctors	75.5%
Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors	74.0%
Indemnity and other insurance costs	73.1%
Availability of good education for children in rural towns	69.6%
Recognition by Government and workforce planners of changing preferences for combining medical / social / family life	68.8%
Flexibility with on call scheduling	68.8%
Raising community support and awareness of implications of losing services	67.6%
Support for secondary education for children	67.5%

Respondents also identified those issues that, while intrinsically important are of lesser significance to members in terms of their current influence on professional, family and community life. The shortlist of issues attracting this lesser priority is as follows:

Table Three: Issues of lowest priority

Category ranked as of highest significance	Percentage
Perceived competition, professional domain and territorial issues	39.3%
Current lack of suitable forms of teaching and training for your requirements	35.4%
Maternity leave policies at your practice	34.8%
Case numbers available locally to ensure currency in your areas of interest	31.7%
Availability of part time registrar / general training options	29.8%
A need for specific policy initiatives for female doctors	27.7%
Special orientation for female doctors on entering rural practice	22.7%
A need for a national network to support female doctors	22.6%
Retraining grants including cover for the cost of childcare	22.3%
Provision of greater / more available support networks and mentors for female doctors	22.1%

4.4 Changing views across RRMA classifications

Having obtained a broad ranking, we then investigated the differences perceived by various sub-groups. We therefore firstly determined the differences created by rurality. While the views of our urban and provincially based members are very important, it is useful to understand the changes to specific issues raised over degrees of rurality that might guide a differential approach to member services by ACRRM.

To this end, Table Four provides a view of changes between rural and non rural data. Comparison measures confirm that RRMA 3 members have no variation in view from RRMA 4-6 and they have therefore been included in the rural cohort.

A special analysis of the requirements of our most remote members has also been undertaken and is outlined in Table Five.

Table Four: Rural and non-rural priorities

Priority issues for RRMA 1-2	Priority issues for RRMA 3-7
Adequate recognition within the practice for the counselling and long consultations provided by female doctors	Government categorisation / recognition of the different requirements of rural and remote practice
Greater recognition by Government of the implications of the feminisation of the medical workforce	Capacity for taking leave with the family
Indemnity and other insurance costs	Greater recognition by Government of the implications of the feminisation of the medical workforce
Recognition by Government and workforce planners of changing preferences for combining medical / social / family life	Adequate recognition within the practice for the counselling and long consultations provided by female doctors
Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors	Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors
Support for secondary education for children	Indemnity and other insurance costs
Levels of colleague or locum support when required	Flexibility with on call scheduling
Availability of good education for children in rural towns	Raising community support and awareness of implications of losing services
Flexibility of practice arrangements especially when children are young	Availability of good education for children in rural towns
Incentives that reflect the type of practice routinely done by female doctors to attract more females to rural practice	Changing patterns of litigation

Typically, the preservation of the field of rural and remote medicine and the need for Government to continue to recognise its unique requirements is the main priority for the rural and remote subgroups in a number of data configurations.

In common is the desire to have recognition within both community and practice setting for the particular contributions of female doctors to the range of skills and services and the need for flexibility in various forms in terms of the choices available for themselves and their families. Access to good education is a recurring theme in both quantitative and qualitative data.

A number of the rural cohort continues in procedural medicine. A specific data set was developed for this cohort. The issue of litigation and indemnity and insurance was raised strongly here as was succession planning. Indemnity continues to be a general issue of concern throughout the data sets.

4.5 Priorities of the most remote women doctors

Continuing the differentiation across RRMA groups, the subset of data below indicate the priorities of the 6.5% of respondents who serve the most remote practices. Members in RRMA 7 indicate the following priority influences on their capacity and satisfaction levels as a professional, family and community member.

Table Five: Priorities from RRMA 7 doctors

Priorities for RRMA 7 doctors
Government categorisation / recognition of the different requirements of rural and remote practice
Capacity for taking leave with the family
Ability to take leave for training – time constraints, professional limitations
Changing patterns of litigation
Indemnity and other insurance costs
Availability of good education for children in rural towns
Greater recognition by Government of the implications of the feminisation of the medical workforce
Raising community support and awareness of implications of losing services
Levels of colleague or locum support when required
Local / regional skills maintenance and up skilling at reasonable cost
Opportunities for compatible employment for spouse
Retraining opportunities in procedural work
More flexible options for postgraduate and professional training

In addition to those common priorities emerging as important for all groups, remote doctors also highlight the requirement for more accessible education and support. The views of procedural doctors are also picked up here in the need for procedural upskilling and flexible options for advanced training. These priorities are also consistent with the subset of procedural female doctors throughout the RRMA classifications.

4.6 Differences with age group

The literature indicates that age differences and stages of family life are likely to influence the priorities of female doctors. Within the ACRRM membership the following variations are evident.

Table Six: Differences with age group

Priorities 40 years and below	**Priorities 41 years+**
Greater recognition by Government of the implications of the feminisation of the medical workforce	Government categorisation / recognition of the different requirements of rural and remote practice
Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors	Capacity for taking leave with the family
Adequate recognition within the practice for the counselling and long consultations provided by female doctors	Indemnity and other insurance costs
Additional tax incentives to cover professional	Adequate recognition within the practice for the

expenses / childcare	counselling and long consultations provided by female doctors
Capacity for taking leave with the family	Greater recognition by Government of the implications of the feminisation of the medical workforce
Support for secondary education for children	Raising community support and awareness of implications of losing services
Local / regional skills maintenance and up skilling at reasonable cost	Changing patterns of litigation
Government categorisation / recognition of the different requirements of rural and remote practice	Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors
Availability of good education for children in rural towns	Recognition by Government and workforce planners of changing preferences for combining medical / social / family life
Flexibility with on call scheduling	Availability of good education for children in rural towns
Levels of colleague or locum support when required	Flexibility with on call scheduling

Again there are many issues in common; however the younger cohort raises the important issues of the decision-making and expense related to secondary education for children and the need to provide balance between the professional and financial rewards of practice and the attendant costs of family care and education. The need is evident for flexibility, for support by colleagues and for recognition through financial incentives and tax structure of the additional costs of rural practice on the family unit. Current research indicates that these preferences are not limited to women doctor groups but also provide a strong thread through the practice requirements of young male doctors.

4.7 Trends in different states

There are also distinct differences in priority issues between the states. Local conditions, demographics and geography can influence choices, as can the local availability of support that may already address issues that remain problematic in other states. The research therefore tested the range of issues by state in order to clarify these differences. Table Seven below provides the top three issues identified by doctors in each state.

Table Seven: Priorities by State

State	Priority issues
New South Wales	1. Government categorisation / recognition of the different requirements of rural and remote practice 2. Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors 3. Capacity for taking leave with the family
Northern Territory	1. Greater recognition by Government of the implications of the feminisation of the medical workforce 2. Capacity for taking leave with the family 3. Recognition by Government and workforce planners of changing preferences for combining medical / social / family life
Queensland	1. Government categorisation / recognition of the different requirements of rural and remote practice 2. Capacity for taking leave with the family 3. Greater recognition by Government of the implications of the feminisation of the medical workforce
South Australia	1. Greater recognition by Government of the implications of the feminisation of the medical workforce 2. Indemnity and other insurance costs 3. Adequate recognition within the practice for the counselling and long consultations provided by female doctors

Tasmania	1. Government categorisation / recognition of the different requirements of rural and remote practice 2. Greater recognition by Government of the implications of the feminisation of the medical workforce 3. Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors
Victoria	1. Flexibility with on call scheduling 2. Adequate recognition within the practice for the counselling and long consultations provided by female doctors 3. Local / regional skills maintenance and up skilling at reasonable cost
Western Australia	1. Government categorisation / recognition of the different requirements of rural and remote practice 2. Support for secondary education for children 3. Supporting your ability as a doctor to respond to community needs
Australian Capital Territory	1. Government categorisation / recognition of the different requirements of rural and remote practice 2. Greater recognition by Government of the implications of the feminisation of the medical workforce 3. Recognition by Government and workforce planners of changing preferences for combining medical / social / family life

4.8 Summary of quantitative findings

What emerges from the analysis of subsets of the membership is that, allowing for some specific variation stemming from remoteness, procedural load and stages of family life, there is a consistent prioritisation of the issues that lead to:

- Recognition for the professional domain of rural and remote medicine
- Recognition at the practice level of the particular contribution of female members of the practice
- Adequate and appropriate financial reward for specific consultation modes and patterns
- Flexibility in terms of professional schedules
- Development of career structures that allow time for family and community involvement, quality leave time
- Opportunities for professional development and upskilling that are accessible and appropriately supported.

4.9 Resume of qualitative data

Comments cover a wide range of issues and attitudes. The range is exemplified by the selected comments below and the qualified comment provided, that touches both ends of the debate between sacrifice and service. One respondent asks:

> *How come what we do is worth so little yet expected and demanded so much by society and Government. How can we keep doing this, even if we believe it is important? We are covering the true cost personally and professionally.* [68]

While another respondent comments:

> *I'm not sure that the issues I think are important are important just because I am female. I think these issues are relevant for male doctors too. Something which seems to be missing is the commitment and responsibilities that go with the privilege of being a doctor / being a family member of a doctor. Without wanting to sound masochistic, I don't think it's unreasonable for doctors to have to make some sacrifices in return for the*

[68] Verbatim respondent comment

privileged position we hold in our society. Service in areas of unmet need is an example of one of these sacrifices. Funny thing is – it is so fulfilling and you learn so much about medicine, life and yourself that it really is not a sacrifice at all but a huge gift. I just wish that more doctors could understand this.[69]

Issues raised in the qualitative comments broadly cover the following points which have been grouped into five strategic themes:

4.9.1 Recognition and status

- The perception that part time doctors are regarded as less valuable professionally.
- Financial recognition in terms of item numbers and practice arrangements that reflect the type of consultation patterns of some women doctors.
- The perception of being less valued in some cases because of not wishing to take on a procedural workload.
- Being regarded less formally than male doctors by practice staff and patients in terms of professional status.
- Inadequate recognition and remuneration for women's health and mental health/psychiatric care.
- The need to provide, promote and support a greater number of female medical representatives and role models and the need for ACRRM to take a lead in this activity.
- Greater understanding within the practice of timing and appointment challenges related to long and complex consults.
- The imposed specialisation with regard to certain areas of care that is noted by some women doctors and which needs to be more formally recognised.
- Community re-education and recognition about the changes occurring in the workforce in terms of both personnel and patterns of service.
- Specific community expectations of the female doctor and the pressures associated with this.
- The problems associated with growing older in a practice and having fewer colleagues coming along to take over the procedural load. This is an issue for both genders.
- Greater support required for the female locum.
- The pressures associated with continuance of practice in order to maintain the mix and service capacity of the local team.

[69] Respondent comment

- The ongoing load of administration and paperwork intruding into the provision of service.

- Justice in the rights of all practitioners to access the benefits and PIP payments going to the practice.

- Differential payments for part time doctors for medical associations, professional development courses.

- The current gender imbalance in doctors who are principals in practice and the implications for young doctors not wishing to take on this role.

4.9.2 Professional development

- The requirement for a more flexible funding framework in support of access to specialist procedural training.

- Regional opportunities to access professional development and procedural upskilling in order to combine family requirements and training.

- The cost of maintaining professional memberships and paying course costs, particularly if part time practice or on maternity leave.

- Specific opportunities for upskilling in mental health.

- The provision of greater corporate and business training for women to run practices.

- Specific leadership development for women.

- Specific educational and support structures for part time doctors to maintain skills and confidence.

4.9.3 Workforce planning

- Recognition that the increasing numbers of female doctors and their responding requirements are not being sufficiently factored into some regional plans by Government funded agencies or being addressed quickly enough to meet rates of workforce change.

- Regulations in some states that preclude part time and non Visiting Medical Officer (VMO) doctors having rights to private practice, an issue that particularly impacts on women doctors.

- A number of cultural issues that need to be recognised and addressed in the female doctor's service to some rural communities and assistance provided in terms of orientation, community education and support.

- Greater forward planning for the predicted increase in two doctor families.

4.9.4 Support structures

- The cost of support frameworks against a salary that is less than average in terms of return for time expended.
- Lack of access to child care and family support in situations where a two doctor family is maintaining the services for a rural community.
- Urgent and appropriate locum relief required for family emergencies as a priority by the appropriate agencies and this locum relief to be appropriately indemnified to meet the practice requirements.
- Greater recognition of the employment needs of family members of rural doctors.
- The mentoring of young doctors, irrespective of gender is recognised as an important support structure.
- The need for communities to be briefed regularly on how to welcome and support their locum workforce.

5. DISCUSSION

5.1 Issues across genders

It is evident that many of the issues that have been raised in connection with women doctors apply equally to their male colleagues. Current data on the priorities of junior doctors in Australia indicate a preference for a balance of work, family and community involvement that has not been typical of the over-committed procedural and generalist doctor to date.

5.2 Recognition of rural medicine

ACRRM female members speak clearly as professionals and committed rural doctors, concerned with the future prospects for their profession in terms of its national recognition by Government and its importance to the rural communities they serve. ACRRM members may or may not be typical of the female doctor cohort nationally, but one of the principal messages provided by this data is that concern for the recognition and preservation of rural medical practice as a distinct profession transcends gender and that issues that relate to professional satisfaction and recognition rate equally highly with issues directly related to the family.

5.3 Recognition of the contribution to practice

ACRRM members have raised the issue of an ongoing reservation about the female doctor in many practice situations. The nub of the argument is the perceived value placed on the contribution of women doctors who may not be full time, or be proceduralists or have the capacity to take after hours or on-call or not be principals. These factors influence the way women are viewed in terms of their contribution to the practice and their rights as a colleague. The degree to which service needs steer the women doctor into areas of enforced

specialisation or preclude options to take a broader range of consultations needs further examination. The value placed on the longer consultation in terms of industrial reward and its value in terms of serving community needs requires thought as does the real benefit to other doctors' roles in many women doctors taking the principal counselling and mental health workload in their practice. It is evident from comments in the survey that members in some practices consider themselves to be disadvantaged by current attitudes.

5.4 Balance of professional and personal lives

The evidence suggests that if female doctors are to be encouraged to practice in rural and remote locations, effective strategies that seek to achieve balance within their professional and personal responsibilities must be implemented, particularly given the increasing number of women now entering medicine and generalist practice.

To further encourage women into rural practice, consideration must also be given to the professional environment in which female practitioners are expected to function. The development of sustainable practice arrangements that have the flexibility to incorporate family demands will do much to increase the attractiveness of rural practice to female practitioners whilst also improving levels of professional satisfaction. Flexibility in work hours, appropriate remuneration and entitlements, and access to appropriate childcare and locum services would serve as further incentives to practice in a rural or remote location.

However, it is clear from the literature that young doctors of both genders are likely to put their family ahead of any professional concerns in terms of long term satisfaction and that there is a need for the greater promotion of the family and personal support services available to practitioners within their immediate area. Rural communities trying to attract young doctors need to be better informed of the particular family concerns and how to best support or accommodate these. This is particularly important in regard to partner employment, education opportunities for children and social isolation for both female practitioners and their partners.

5.5 Flexible access to education and training

Whilst access to CME and other forms of professional development and support have improved over the past decade, there are still many barriers to be overcome. There is a need for greater flexibility in the provision of professional development activities and increased local and regional area education opportunities. The provision of appropriate locum services would greatly assist rural female practitioners to attend relevant educational events and provide opportunities to network with a broader range of colleagues.

6. FORWARD PLANNING

This research study highlights some of the challenges and opportunities identified by female members of the rural College. In response, ACRRM is making these results widely available to interested organisations and individuals in Australia to encourage a process of discussion and to develop the means to address some of the priority issues raised by the research. ACRRM will be seeking a broader audience for these findings, advocating key issues to appropriate organisations and seeking opportunities to link with national processes of support for female doctors. A "Strategic Solutions Paper" will be developed as an outcome of the consultation

process. By these means, ACRRM intends to promote relevant and achievable program outcomes for the consideration of funding agencies and supporting bodies.

Through its WIRP group, ACRRM will consider strategies to respond to the priorities of its members and seek to engage a broader cross section of the female medical workforce in its activity.

The similarity between many of the issues raised by women doctors, and the needs and aspirations of young male doctors has not been overlooked. Initiatives emerging from this activity will enlarge the capacity of the rural College to address the education and support requirements of current generalist and specialist registrars interested in a sustainable career and a good lifestyle in rural medicine for themselves and their families.

Acknowledgements:

We wish to thank the female medical members of ACRRM for their generous contribution to this research.

Acknowledgement to the research and academic personnel and the Rural Workforce Agency staff who's work in support of women doctors provided the basis for the issues used in the ACRRM research.

Acknowledgement of the work of the ACRRM WIRP group in contributing to the issues used in the survey.

Thanks to Anna Nichols and Yolanda Schweizer in the ACRRM Research, Evaluation and QA section for their work on the project. Correspondence to a.nichols@acrrm.org.au

ATTACHMENT ONE: Survey

SUPPORT FOR FEMALE RURAL AND REMOTE DOCTORS

ACRRM is investigating the importance to female rural and remote doctors of the following issues. Many will influence your professional, family and community life to a certain extent.

In order to ensure that ACRRM can respond appropriately to the issues that are most important to you - would ***you please rate their importance using the scale below:***

3. Significant importance ***2. Moderate importance*** ***1. Lesser importance***

Policy and national issues affecting female doctors

	Significant	*Moderate*	*Lesser*
A need for specific policy initiatives for female doctors	3	2	1
A need for a national network to support female doctors and their issues	3	2	1
A need for changes in national attitudes with regard to the value placed on female doctors' contributions	3	2	1
Greater recognition by government of the implications of the feminisation of the medical workforce	3	2	1
Government categorisation/ recognition of the different requirements of rural and remote practice	3	2	1
Current government policies on health care delivery that influence your practice	3	2	1
Regulatory/ recognition issues between Colleges	3	2	1
The level of rural focus of professional organisations	3	2	1
Current trends towards centralisation of services	3	2	1

Practice in the rural community

	Significant	*Moderate*	*Lesser*
Importance of communities targeting the recruitment of female doctors	3	2	1
Special orientation for female doctors on entering rural practice	3	2	1
Raising community support and awareness of implications of losing services	3	2	1
Supporting your ability as a doctor to respond to community needs	3	2	1
Pressures owing to community preference for the same gender doctor	3	2	1
Imposed specialisation – women's health	3	2	1
Adequate recognition within the practice for the counselling and long consultations provided by female doctors	3	2	1

Safety issues with after hours and on-call	3	2	1
Maternity leave policies at your practice	3	2	1
Flexibility of practice arrangements especially when children are young	3	2	1
The capacity to job share	3	2	1
Flexibility with on-call scheduling	3	2	1
Case numbers available locally to ensure currency in your areas of interest	3	2	1
Levels of colleague or locum support when required	3	2	1
Opportunities for compatible employment for spouse	3	2	1
Capacity for taking leave with the family	3	2	1
Perceived competition, professional domain and territorial issues	3	2	1

Education and training

	Significant	*Moderate*	*Lesser*
Ensuring that medical training at each stage recognises the types of practice and principal issues of female doctors	3	2	1
More positive and routine rural female doctor input to medical training and teaching	3	2	1
Current lack of suitable forms of teaching and training for your requirements	3	2	1
Lack of appropriate recognition/ reward for teachers and mentors	3	2	1
Ability to take leave for training – time constraints, professional limitations	3	2	1
Access to training/ retraining to suit patterns of consultation	3	2	1
Availability of part-time registrar/ general training options	3	2	1
More flexible options for postgraduate and professional training	3	2	1
Local/ regional skills maintenance and upskilling at reasonable cost	3	2	1
Retraining opportunities in procedural work	3	2	1
Pressures of maintaining a broad range of skills	3	2	1
Retraining grants including cover for the cost of childcare	3	2	1

Support - resources and personnel

	Significant	*Moderate*	*Lesser*
Specifically skilled locum provision for your type of practice	3	2	1
Access to specialists – resident/ visiting for appropriate training and backup	3	2	1
Partnering – levels of access to colleagues with complimentary skills	3	2	1
Access to auxiliary health personnel	3	2	1
Provision of greater/ more available support networks and mentors for female doctors	3	2	1

Legal and financial issues

	Significant	*Moderate*	*Lesser*
Changing patterns of litigation	3	2	1
Indemnity and other insurance costs	3	2	1
Incentives that reflect the type of practice routinely done by female doctors to attract more females to rural practice	3	2	1
Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors	3	2	1
Costs of professional memberships	3	2	1
Costs of upskilling versus income recovery	3	2	1
Additional tax incentives to cover professional expenses/ childcare	3	2	1

Family and personal issues

	Significant	*Moderate*	*Lesser*
Recognition by government and workforce planners of changing preferences for combining medical/social/ family life	3	2	1
Support for the families of female doctors built into recruitment strategies	3	2	1
Greater promotion of female doctors into leadership and decision-making	3	2	1
Living and working in the same community	3	2	1
Challenges in maintaining your own health	3	2	1
Provision or assistance with childcare and domestic responsibilities	3	2	1
Availability of good education for children in rural towns	3	2	1
Support for secondary education for children	3	2	1

The future

	Significant	*Moderate*	*Lesser*
Providing new models of training to respond to the feminisation of the workforce	3	2	1
Providing new models of training/ skills maintenance for part time doctors	3	2	1

COMMENTS

Have we missed a key issue? Please provide details and we will include your feedback.

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When you have completed your rating, will you please re-visit the issues above and identify (tick) the five issues that you believe should be addressed at the highest priority.

Thank you for your assistance we will provide feedback on the results.

Please return this survey in the envelope provided or fax back by Friday 4 July 2003 - to Anna Nichols at ACRRM – 07 3105 8299.

ATTACHMENT TWO: Full ranking of significant issues: aggregate data

Rank	Code	Item	Percentage	Frequency
1	A5	Government categorisation / recognition of the different requirements of rural and remote practice	81.1%	167
2	B16	Capacity for taking leave with the family	76.0%	158
3	A4	Greater recognition by government of the implications of the feminisation of the medical workforce	75.5%	157
4	B7	Adequate recognition within the practice for the counselling and long consultations provided by female doctors	75.5%	157
5	E4	Item number recognition of longer consultations as a reflection of the pattern of practice of female doctors	74.0%	154
6	E2	Indemnity and other insurance costs	73.1%	152
7	F7	Availability of good education for children in rural towns	69.6%	144
=8	F1	Recognition by government and workforce planners of changing preferences for combining medical / social / family life	68.8%	143
=8	B12	Flexibility with on call scheduling	68.8%	143
9	B3	Raising community support and awareness of implications of losing services	67.6%	140
10	F8	Support for secondary education for children	67.5%	139
11	E1	Changing patterns of litigation	67.1%	139
12	B8	Safety issues with after hours and on call	66.8%	139
13	B14	Levels of colleague or locum support when required	66.7%	138
14	C9	Local / regional skills maintenance and up skilling at reasonable cost	64.7%	134
15	B10	Flexibility of practice arrangements especially when children are young	62.0%	129
16	B4	Supporting your ability as a doctor to respond to community needs	61.7%	127
17	G2	Providing new models of training / skills maintenance for part time doctors	61.1%	124
18	C11	Pressures of maintaining a broad range of skills	60.9%	126
19	B11	The capacity to job share	60.9%	126
=20	A3	A need for change in national attitudes with regard to the value placed on female doctors' contributions	58.2%	121
=20	E3	Incentives that reflect the type of practice routinely done by female doctors to attract more females to rural practice	58.2%	121
=21	E7	Additional tax incentives to cover professional expenses / childcare	57.5%	119
=21	F2	Support for the families of female doctors built into recruitment strategies	57.5%	119
22	B15	Opportunities for compatible employment for spouse	56.3%	117
23	E6	Costs of up skilling versus income recovery	55.6%	114
24	C10	Retraining opportunities in procedural work	55.3%	114
25	C12	Retraining grants including cover for the cost of childcare	54.4%	110
25	G1	Providing new models of training to respond to the feminisation of the workforce	54.4%	111
26	E5	Costs of professional memberships	53.8%	112
27	F3	Greater promotion of female doctors into leadership and decision making	52.7%	108

28	A9	Current trends towards centralisation of services	52.4%	108
29	C8	More flexible options for postgraduate and professional training	52.2%	106
30	A8	The level of rural focus of professional organisations	50.0%	104
31	F6	Provision or assistance with childcare and domestic responsibilities	49.8%	102
32	C2	More positive and routine rural female doctor input to medical training and teaching	49.5%	103
=33	C5	Ability to take leave for training – time constraints, professional limitations	47.3%	98
=33	A6	Current government policies on health care delivery that influence your practice	47.3%	98
=33	F5	Challenges in maintaining your own health	47.3%	98
34	F4	Living and working in the same community	44.2%	91
35	C1	Ensuring that medical training at each stage recognises that the types of practice and principal issues of female doctors	43.0%	89
36	D2	Access to specialists – resident / visiting for appropriate training and backup	42.5%	88
37	A2	A need for a national network to support female doctors and their issues	39.9%	83
38	A7	Regulatory / recognition issues between Colleges	38.6%	80
39	D4	Access to auxiliary health personnel	38.2%	79
40	B9	Maternity leave policies at your practice	37.7%	78
=41	B5	Pressures owing to community preference for the same gender doctor	37.6%	77
=41	C6	Access to training / retraining to suit patterns of consultation	37.6%	77
42	D5	Provision of greater / more available support networks and mentors for female doctors	37.5%	78
43	B1	Importance of communities targeting the recruitment of female doctors	35.1%	73
44	D1	Specifically skilled locum provision for your type of practice	34.6%	71
45	B6	Imposed specialisation – women's health	34.5%	71
46	D3	Partnering – levels of access to colleagues with complimentary skills	34.1%	71
47	C7	Availability of part time registrar / general training options	32.2%	66
48	C4	Lack of appropriate recognition / reward for teachers and mentors	31.4%	65
49	B2	Special orientation for female doctors on entering rural practice	30.0%	62
50	A1	A need for specific policy initiatives for female doctors	28.6%	59
51	B13	Case numbers available locally to ensure currency in your areas of interest	25.2%	51
52	B17	Perceived competition, professional domain and territorial issues	20.4%	42
53	C3	Current lack of suitable forms of teaching and training for your requirements	16.5%	34

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