Chapter 1.3.3

WOMEN AND RURAL MEDICAL PRACTICE: THE IMPORTANCE OF DOING IT DIFFERENTLY IN THE 21ST CENTURY

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Introduction

> *'If we were a group of women practising, we would get that practice right and would make lots of assumptions that we can't change the outside world - whereas I think men tend to make the assumption, which is true, that they have much more power in changing the very frame in which they work. And I think part of this is that one of the reasons why women are locally focused is that that's all they can change. They don't have the systemic links to how society's organized. And so part of the essential difference between men and women, which is talked about in even education for example, is that women are more practice-based or more focused on the local and the actual practice rather than the abstract. It's partly because women can't change the abstract in a way that they might if abstract was constructed as what they know and what they think is important.*
>
> *(Study participant 8)*

The structures and values of rural medical practice were developed at a time when rural doctors were men. Doctors were assumed to have wives to do all the family work and enable the rural doctor to serve his community with the support of his wife managing the home and children. This wife-work enabled the doctor to work extended hours and be constantly available on-call. Rural communities employed the doctor and gave scant attention to his family. Since that time, however, women have been graduating as doctors in almost equal numbers to men, and very few women have the wives or partners on which rural practice was predicated.

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[1] Thanks to Roger Strasser (Northern Ontario School of Medicine) and Lexia Bryant (former president of the Australian College of Rural and Remote Medicine) who supervised and advised the national rural doctor study.

The first attempts to draw women into rural medicine saw heroic efforts to restructure women to work like their male colleagues. After several decades it became apparent that was a fruitless strategy.

Standpoint theory (1), working from women's lives, raises as problematic many things that are constituted as 'natural' and, in their 'naturalness', underpin existing social and professional structures. One example is that women's work in childbearing and rearing and in the general care of bodies is invisible from the dominant perspective, even though it is this invisible work that makes it possible for others to dedicate themselves to socially recognised work. So, also, professional structures are built that depend on, and yet do not recognise, the body work that women do. Training programmes and practice environments in medicine are just such structures. The study reported here makes this work visible and suggests some evidence-based structural changes to address when developing sustainable rural practice for women.

What's the evidence?

The findings reported here are from a 2002 national survey of rural doctors in Australia. The survey was weighted to over-sample women, and was based on an extensive Delphi process (2) with 30 female rural doctors to determine the issues that affect sustainability of rural practice. General practitioners in rural towns with fewer than 25 000 people were the respondents. The response rate was high – with 63% of women (n=604) and 54% of men (n=508) returning usable questionnaires.

Women in the survey were younger while the male doctors more closely matched the age profile of the whole population of general practitioners. The mode for the age of female respondents was 40-44, and for non-respondents[2] it was 45-49. Data on full-time or part-time work for non-respondents were available only for women. Female respondents were less likely to work full-time than non-respondents (64% compared with 74%).

Women's activities were used as the norm and tested to see whether they applied to men as well.

[2] The non-respondent data were from AMPCo (2003). AMA Publishing Company. Sydney, Australian Medical Association. 2004.

The work of rural doctors

One of the ways in which women are transforming medical practice is by making their families visible, and taking their family work into account in determining their approach to professional work. It is increasingly being recognised in rural practice that doctors have families, and that this matters. As part of the process of making the family visible, the survey sought to document how work in the family interacts with professional work.

Nearly all the doctors in the national survey were in a marriage-like relationship and had dependent children (see Table 1). An important minority did not fit this description – with 12%of women and 7% of the men living on their own (with or without children). The remainder were sharing their lives with partners, friends or other family.

Table 1:
Family status of rural general practitioners

Variable	Value	Female		Male		Missing	
		N	%	N	%	Female	Male
Relationship							
	Marriage or de-facto	506	84%	461	91%	8	5
	No partner	74	12%	37	7%		
	Friend	10	2%	6	1%		
	Other family	7	1%	0	0%		
	Other	7	1%	4	1%		
Have dependent children		377	62%	327	64%	4	1
Responsibility for care of children							
	All	52	14%	17	5%	230	181
	Most	166	44%	10	3%		
	Shared	154	40%	249	75%		
	Little	9	2%	54	16%		
	No	1	0%	2	1%		
Care of other family member		105	17%	58	12%	10	15
Mean hours of care for family members during six-day working week		4.7 day	28.2 week	2.5 day	15 week	29	33

Sixty two percent of women and 64% of men had dependent children living with them who required daily support. Fifty eight percent of these women had all or most of the responsibility for their care, compared with 8% of men.

Women were much more likely than men to carry most or all of the responsibility for caring for dependent children. Men are nearly twice as likely to say they share in the care of the children, indicating a substantial difference in world-view about who is doing the work. This is consistent with Quadrio's finding that doctors' wives, whether themselves doctors or not, carry most domestic responsibility (3).
The mean number of hours for those women caring for children or other family members was 4,7 hours on a normal working day, or 28,5 hours per 6 day working week. The mean number of hours for those men caring for children or other family members was 2,5 hours on a normal working day, or fifteen hours per six-day week. Thirty nine percent of men and 22% of women spent no time on family care.

Family work is a key difference between male and female doctors and permeates many of the challenges women face working within a system that ignores their family responsibilities or assumes there is someone at home providing family care. Work, especially work that women do, is much more complicated than the individual patient encounter, or even the booked session. In this study, work was broken down into face-to-face clinical work, other professional work, family work, and community work, reflecting the intellectual and leadership skills that doctors bring to rural communities.

As predicted, doctors work substantially longer hours in clinical practice than they are booked to work. The mean of scheduled working hours per week for women was 26, and the mean of actual hours worked was 33. Eighty one percent of women were scheduled to work the 35 hours or less per week that constitutes part-time in general practice, but only 54% actually did so, with the others working more than the contracted hours.

The male doctors also worked more hours than they were scheduled to work, and worked longer hours than women in clinical practice. The mean number of hours booked for men was 35, and the mean of hours worked was 47 hours.

When the hours of work are aggregated, including caring for family, clinical hours, other professional work and community-based work, men worked a mean of 62 hours and the women worked a mean of 58 hours (assuming a six-day working week for hours of family care, as the variable asked about 'hours on the last normal working day'). This does not include on-call. For those doctors who were caring for family members, the mean hours worked per week was 68 hours for the men, and 62 hours per week for women (see Table 2).

The accuracy of this figure is affected by the non-response bias among women. Women working full-time were under-represented among respondents.

Table 2:
Mean of hours of work per week

	Women			**Men**		
	Mean hours	Median hours	N	Mean hours	Median hours	N
Family work						
All doctors	22	18	583	9	6	480
Caring for dependents	28	24	452	15	12	295
Professional work not including on-call						
All doctors	37	37	480	54	52	439
Caring for dependents	35	35	351	53	52	251
Total hours of work not including on-call						
All doctors	59	55	462	63	60	421
Caring for dependents	63	60	351	68	65	251
Total hours of on-call						
All doctors	30	14	531	50	18	496
Caring for dependents	28	11	392	22	19	287
Total hours of work including family work and on-call						
All doctors	89	74	428	113	81	413
Care for dependents	91	75	324	90	86	247

Men who were not caring for family members had the highest workload of all rural doctors, working a mean of 113 hours per week. Women caring for dependent children had the second highest workload, working an average of 91 hours per week, including family work, professional work and on-call. Men with dependent children worked 90 hours per week.

The mean for hours worked, excluding family care, for those doctors who were caring for family members was 35 hours for women and 53 hours for men. For those doctors who were not caring for family members their mean number of professional hours worked per week was 44 for women and 54 for men. These work hours do not include on-call. Caring for family members leads to a reduction in clinical working hours of 20% for women, but makes no apparent difference for men.

On-call

Being on-call is an aspect of general practice that differentiates rural and urban practice. Like hours of work, on-call is complex to define – but the definition used in this study excludes time spent in face-to-face clinical work.

While most female rural doctors provide on-call cover for their communities, they provide less call than male doctors. Being on-call is highly problematic for women with dependents most of whom are on-call for their families. Women with dependents said they cannot provide after hours care unless childcare is provided.

Domains of practice

Women practice the core aspects of medicine like their male peers, and yet they have key differences in approach – which are partly a response to patient presentations, and partly a reflection of what constitutes professional satisfaction for women. The differences that have been identified are that women take more time in their consultations, address multiple problems in one consultation, and deal more with women's health and mental health issues than male doctors. And they listen.

In this study female rural general practitioners said they spent nearly two thirds of their time providing women's health, mental health, men's health and counselling services to their patients, and male doctors said they spent half of their time (see Table 3). These data provide quantitative and statistical underpinning to the story women have been telling for some time; that they provide time-consuming and complex interventions in response to the needs of their patients; that this is a form of-practice that has a low profile in rural medical politics, is poorly paid, and highly valued by patients.

Table 3:
Mean percentage of clinical time in different domains of practice

Domain of practice	Mean % of clinical time		**Mean Difference**
	Women	**Men**	
Mental health*	15.6%	12.6%	3.0%
Preventative health	14.3%	15.0%	-0.7%
Women's health*	29.9%	12.7%	17.2%
Counselling*	12.1%	9.6%	2.5%
Family violence	2.5%	2.3%	0.2%
Men's health*	5.0%	11.5%	-6.5%
Public health*	2.8%	4.4%	-1.6%
Other general practice*	18.0%	32.0%	-14.0%
Total	100%	100%	

*difference between women and men significant at p<0.000

The difference between the percentage of time spent by women and men in six out of eight domains of practice is statistically significant ($p<0.000$). Perhaps not surprisingly, women spend a much higher portion of their consulting time managing women's health consultations than do. The other differences are statistically significant, but unlikely to be clinically important.

Hospital practice

The hospital-based work of rural general practice is one of the distinguishing features of rural medicine. This study showed that two thirds (66%, n=383) of women and 85% (n=429) of men provide hospital-based care including emergency care, anaesthetics, obstetrics, geriatrics and psychiatry. Just under half - 45% of women and 41% of men - provided general practice services only, while 21% of women and 44% of the men provided general practice care plus specialist care. Women were least likely to provide anaesthetics, and surgery under general anaesthetic.

Most of the women who did not provide hospital-based services did not want to do so. Seventeen women and nine men said they were unable to gain access to the hospital because of barriers put in their way.

The pattern of involvement in hospital care for male and female doctors was similar to that of their engagement with emergency medicine. More men do more of this work than women. The reason is likely to be a combination of the preference of the doctor and the work practices and culture of the hospitals, combined with differing responsibility for family care.

Confidence in managing the emergency care that distinguishes rural practice

One of the defining features of rural practice, in addition to providing hospital-based care and on-call, is the management of medical emergencies and trauma. This section addresses the doctors' experiences with that aspect of medical care in which immediate treatment by a doctor improves the outcome for the patient.

The survey asked how much emergency care doctors provide to their communities, and how confident they are to carry out a sentinel emergency procedure (intubate an unconscious patient). Five separate types of emergency medical care were described, covering the range of emergencies that rural doctors are routinely required to manage.

These were:

1. responding to trauma;
2. dealing with an acute medical or psychiatric illness;
3. providing initial assessment in a life-threatening situation;
4. resuscitating a critically ill patient; and
5. stabilising a critically ill patient for transfer.

Emergency medical care

Eighty six percent of female doctors and 93% of male doctors provided at least some emergency care to their communities - with 38% of women and 69% of men sharing, or providing most or all of, this care. The difference between the sexes is statistically significant (p=.000) (2 tailed, Pearson coefficient 124.051, df 4). The number of times they had performed each of the five types of emergency care over the past year are reported in Table 4.

Table 4:
Episodes of emergency medical care over the past year

N Valid F 583 M 490 N Missing F 29 M 23	Times attend roadside or trauma in past year		Times attend acute medical or psychiatric in past year		Times assess life threatening situation in past year		Times resuscitated critically ill patient in past year		Times stabilised patient for transfer in past year	
	F	M	F	M	F	M	F	M	F	M
Mean including 0[3]	3.43	8.2	18.01	44.08	3.83	10.92	1.83	4.44	2.45	5.31
Mean excluding 0	11.69	14.83	19.55	47.26	6.08	13.08	4.49	6.27	5.19	7.01

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[3] Twenty nine women and 23 men have missing values for all five variables. For those cases with intermittent missing data, where there was data in at least one of the variables, missing values were assigned the value of 0 on the assumption that if doctors had provided this type of care they would both remember and report it, given that for most of them it would be an occasional and challenging experience. This is likely to result in an underestimate of the mean. The mean for those doctors who reported having provided episodes of emergency care are reported in addition to the mean for all women and all men.

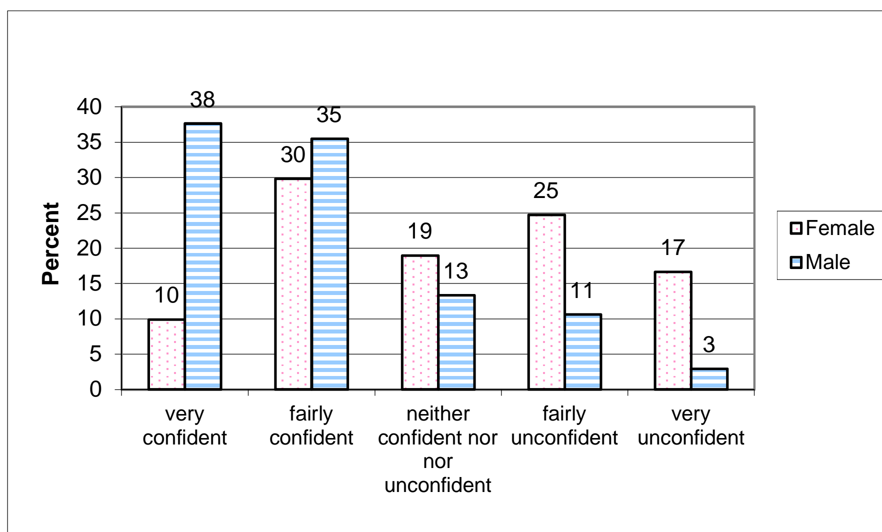
Men provide more episodes of emergency care than women, for each type of care, particularly attending to acute medical or psychiatric illness. Resuscitating a critically ill patient, and stabilising a patient for transfer were rare events for doctors of both sexes. The difference between women and men in provision of emergency services is statistically significant for each type of emergency care. There is likely to be more to this than a lower exposure to medical emergencies because of fewer hours of clinical practice, as we shall see.

Confidence to intubate unconscious patient

Men in this survey were more confident than women to intubate an unconscious patient. There is a statistically significant difference in confidence to intubate an unconscious patient for women and men (Mann Whitney U test z=-13.40, p=.000) (see Figure 1).

The women were divided equally regarding their confidence: 40% (n = 242) were very or fairly confident, 19% (n = 116) were neither confident nor unconfident, and 41% (n = 251) were either unconfident or very unconfident. Nearly three quarters of the men (73%, n = 373) were very or fairly confident to intubate an unconscious patient, 13% (n = 68) were neither confident nor unconfident, and 13% (n = 69) were either unconfident or very unconfident.

Figure 1:
Confidence in intubating an unconscious patient, by sex



Whether confidence equates with competence has not been explored in this study; however the sustained attempts to impose masculine culture on women doctors is likely to be a major factor in undermining the confidence of women doctors. Quadrio has identified that at similar levels of competence 'women consistently rate themselves lower than do their male peers' (Quadrio 2001 p218). If women do not feel confident to manage medical emergencies, then we can expect them to structure their practice to avoid responsibility for emergency medicine.

There is anecdotal evidence that some women were put off training in emergency medicine by the culture of the training environment. It was a particularly important finding that women who were less confident were more likely to prefer an educational programme run by women.

Discussion

An important cultural change that rural women doctors have implemented is that of putting limits to their practice, and establishing clear boundaries between their professional and personal lives. This is hard to do for a rural doctor. The men who preceded them and established the culture of rural practice have left a legacy of the rural doctor always at the service of his community, prepared to die with his boots on – and many of them did – with a wife providing all the invisible family services that support this type of engagement with profession and community.

Women found that this cultural practice does not take into account the complexity of their lives and they needed to do something about that. So first they made their families visible, then put limits to their practice. Women pay a price for this strategy, yet they seem determined to implement it against considerable pressure to work longer hours in clinical practice.

An illustrative anecdote/case studies

The following comments were made by women rural doctors who participated in this study.

> *"I have medical students in my practice - mostly women - for about six weeks a year. My students make me feel very special and value the example I set as a role model."*

> *"Women just have to do it the best they can. A lot of people do job share during the year they are having their baby. It's becoming more and more acceptable. We were the first to do it, back then - 1997 I think. It was very difficult for our training consultants to do it at the time, but it's becoming much more acceptable; well they are getting used to it I guess. … I mean we are talking about women who start their training programme at the age of 25 or 26. It is a six-year training programme so, as they get towards the end of it, you're talking 30+ – it's time for them to have their babies. So they job share or they do a research year."*

> *"A lot of it is to do with having children, which is the most powerful life-changing forces that there are. And I spend quite a lot of time talking to my younger colleagues about giving themselves enough space to allow that to be available and not trying to compartmentalise having kids into a neat little corner; fit it into the weekend sort of thing. So that biological fact has got tremendous power and tremendous release and gives you tremendous capacity to understand more about yourself than almost anything else, I think."*

Broader applicability and implementation

Flexible practice structures that allow female rural doctors to be women as well as doctors are being implemented by women. They have worked flexible hours, changed waiting rooms and patient information practices, structured communication with practice staff, established co-operative working arrangements with male colleagues, shared on-call and time off after being on-call, set limits, built in time for paperwork, accepted help from colleagues, worked in salaried positions, scheduled appointments to leave time for emergencies, set up practices where all doctors work part-time, and found supportive professional and life partners. These women are transforming rural practice.

Women seem to be more able than men to set limits to their practice. Women are perhaps harder to tame than men - less easily lured by promises of money and status to do the work of two when they are only one. The shortage of rural doctors gives them leverage to require that their complex lives be taken into account when structuring rural practice and they resist considerable pressure to overwork and to be constantly on-call.

Women are leading the way in implementing flexible practice models, and changing rural practice as they go; they are changing the very frame in which doctors work.

Practice pearls

- More women will become rural doctors when the structure of practice reflects the way women live their lives and practice medicine.

What to do

- Create flexible patterns of practice to encourage women to become rural doctors.
- Recognise that female rural doctors are on-call for their families as well as their community and put in place systems to support this.
- Create models of 'easy entry/graceful exit' [4]to rural practice to allow men and women doctors to work in rural areas when family structure permits, and leave and return when circumstances change.
- Ensure there is a place in the community for the whole family.
- Structure continuing medical education to make it accessible for all rural doctors.

Do not to do

- Do not assume that women can be restructured to behave like men.
- Avoid the assumption the rural doctors will work the hours of two people.
- It is not sustainable to pay for one doctor when two or more are needed.
- Recruiters to rural practice must avoid assuming the doctor has no family.

Conclusion

This study has demonstrated that women and men work as hard as each other, but that women distribute their work more evenly between professional tasks and family and community than do men.

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[4] I am indebted to the New South Wales Rural Doctors Network for this phrase (http://www.nswrdn.com.au).

The expectation that the rural doctor be available at all times no longer fits the incoming rural general practice workforce. Women are requiring that alternative ways to meet community need must be devised, for the wellbeing of both the community and the doctor and their family. They challenge the rhetoric that 'Super Doc' is the only way to be a rural doctor, and describe medical encounters where their female ways of practice have led to positive outcomes for the patient; they have changed the way rural medicine is practised so that they can be women as well as doctors, and have lives too.

The purpose of medical education and training is to produce confident, competent doctors. All areas of medical education could benefit from acting on the finding that models in which women are absent are clearly no longer best practice.

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