

2005

## The changing face of rural general practice: an ethnographic study of general practitioners and their spouses

Angela Durey  
*Edith Cowan University*

Follow this and additional works at: <https://ro.ecu.edu.au/theses>



Part of the [Health and Medical Administration Commons](#), and the [Rural Sociology Commons](#)

---

### Recommended Citation

Durey, A. (2005). *The changing face of rural general practice: an ethnographic study of general practitioners and their spouses*. Edith Cowan University. Retrieved from <https://ro.ecu.edu.au/theses/61>

This Thesis is posted at Research Online.  
<https://ro.ecu.edu.au/theses/61>

2005

# The changing face of rural general practice: an ethnographic study of general practitioners and their spouses

Angela Durey  
*Edith Cowan University*

---

## Recommended Citation

Durey, A. (2005). *The changing face of rural general practice: an ethnographic study of general practitioners and their spouses*. Retrieved from <http://ro.ecu.edu.au/theses/61>

This Thesis is posted at Research Online.  
<http://ro.ecu.edu.au/theses/61>

# Edith Cowan University

## Copyright Warning

You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorize you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.
- A reproduction of material that is protected by copyright may be a copyright infringement. Where the reproduction of such material is done without attribution of authorship, with false attribution of authorship or the authorship is treated in a derogatory manner, this may be a breach of the author's moral rights contained in Part IX of the Copyright Act 1968 (Cth).
- Courts have the power to impose a wide range of civil and criminal sanctions for infringement of copyright, infringement of moral rights and other offences under the Copyright Act 1968 (Cth). Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.

## USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

## **ABSTRACT**

‘Rural general practice is general practice at its best’: a comment by one GP interviewed for this study was echoed by colleagues who viewed their work in a rural setting as challenging, diverse, rewarding and satisfying. Despite reported difficulties associated with rural general practice, many GPs argued that the benefits outweigh the disadvantages. Few wanted to leave. Nonetheless, too few Australian trained GPs are willing to move from cities to work in the country. Consequently, overseas trained doctors have been recruited to fill vacancies or nurses provide health services in communities unable to attract a GP.

This thesis adds to findings of previous studies by critically examining structural issues affecting decisions made by GPs and their spouses to work in country areas. First, it discusses the impact of gender as a structural force on the expectations and experiences of rural GPs and their spouses, a theme rarely considered in studies on recruitment and retention. Increasing numbers of women are entering the medical profession and wanting changes to inflexible work patterns. Many prefer working fewer hours to balance the demands of medical practice and family, an option also favoured by some male GPs. Male spouses of rural GPs are more likely to work in their chosen occupation while female spouses often subordinate their career aspirations to support those of their GP partner. Such issues are considered in the context of providing rural GP services. Second, the study explores how political and economic changes have affected rural general practice. Neoliberal policies focusing on competition and cost effectiveness are driving the allocation of health care resources and impacting on the autonomy and control of rural GPs over their work practices. Governments have increasingly intervened in clinical practice amid calls for accountability and threats from patients of medical litigation. Other health professionals are also competing to provide services once offered exclusively by the medical profession. In the face of such developments, many rural GPs feel uncertain, insecure and frustrated.

Ethnographic methods, including participant observation, in-depth interviews

and informal discussions, are used to identify the behaviour, satisfactions, frustrations and hopes of both Australian trained and overseas trained GPs and their spouses living and working in the area covered by the Great Southern Division of General Practice in rural Western Australia. Few studies have focused on overseas trained doctors' expectations and experiences of rural general practice in Australia. Even though most rural GPs are married or in committed relationships, research on expectations and experiences of GPs' spouses/partners is limited. This project fills the gap.

In analysing the relationship between structural issues and social practice, the thesis builds on the foundational work of Gramsci and Bourdieu and draws also on theoretical insights developed by Connell and others. It focuses on the concept of power to examine how enduring patterns of social relations are either reproduced or contested in a rural general practice setting. The study concludes that critically examining the relationship between structural factors and social practice offers a more nuanced appreciation of the range of influences affecting the lives of rural GPs and their spouses. This leads to the conclusion that, without understanding this relationship, we are likely neither to overcome the difficulties of recruitment and retention, nor to adequately address the broader problems of rural health care.

## DECLARATION

*I certify that this thesis does not, to the best of my knowledge and belief:*

- (i) incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education.*
- (ii) contain any material previously published or written by another person except where due reference is made in the text; or*
- (iii) contain any defamatory material.*

*I also grant permission for the Library at Edith Cowan University to make duplicate copies of my thesis as required.*

Signature: .....

Date: .....

## ACKNOWLEDGEMENTS

This thesis could not have been written without the support of a range of people. First, I extend a sincere thank you to my supervisors, Alan Black, John Duff and Ann-Claire Larsen for their knowledge, insights and experience. I valued their constructive feedback, sound advice, and encouragement to dig deeper and go the distance. Thanks also to Sherry Saggars, Director of the Centre of Social Research at Edith Cowan University for her support throughout the PhD journey and Ann Larson, Director of the Combined Universities Centre for Rural Health for setting me on this road in the first place.

I acknowledge and appreciate the partial funding for this project from the Australian Research Council. My appreciation also goes to the Great Southern Division of General Practice for assisting with the funding and providing support throughout the research. Sincere thanks are also extended to all participants who were involved in this research. I greatly valued their generosity in giving up their time so willingly and the candour with which they related their experiences.

Thank you also to Rose Durey for proof reading the thesis, to Liz Roberts for her comments on various drafts and to my friends, for their unfailing belief in me, their encouragement when I felt like giving up and their understanding when I was unavailable and preoccupied. And thank you to my children and family for their love, support and generosity. They made me realise that life goes on despite the thesis, that humour is vital and that taking myself too seriously is not on the agenda.

# TABLE OF CONTENTS

USE OF THESIS .....	i
ABSTRACT .....	ii
DECLARATION .....	iv
ACKNOWLEDGEMENTS .....	v
TABLE OF CONTENTS .....	vi
LIST OF TABLES .....	xi
LIST OF MAPS .....	xi
FIGURES .....	xii
ABBREVIATIONS AND ACRONYMS .....	xiii
INTRODUCTION .....	1
Rural general practice .....	2
The social practice of gender .....	10
<i>Female rural GPs</i> .....	10
<i>Rural GPs' spouses</i> .....	11
The effects of political and economic change .....	12
<i>Rural centres</i> .....	12
<i>Rural health services</i> .....	13
Purpose of the study .....	15
Areas of enquiry .....	16
Chapter overview .....	16
CHAPTER 1 The changing face of rural general practice: the relationship between structure and social practice .....	19
Hegemony .....	21
Resistance .....	29
Gender as social practice .....	30
Political and economic changes and rural general practice .....	32
Situating the study .....	35
<i>Feminisation of medical profession</i> .....	35
<i>Gender relations in the home</i> .....	38

<i>Effects of political and economic change on medical work practices .....</i>	<i>40</i>
<i>Resistance to medical hegemony in rural health care .....</i>	<i>44</i>
<i>Rural restructuring and development .....</i>	<i>47</i>
<i>Effects of social change on rural medical service provision .....</i>	<i>49</i>
<i>Rural GPs' responses to structural change .....</i>	<i>54</i>
CHAPTER 2 Recruiting and retaining GPs and their spouses/families in rural locations.....	56
The social practice of rural health care .....	58
Recruitment of rural GPs .....	61
<i>Incentives for Australian trained doctors .....</i>	<i>61</i>
<i>Incentives for overseas trained doctors .....</i>	<i>69</i>
<i>Western Australia.....</i>	<i>71</i>
<i>Maintaining medical care in rural locations .....</i>	<i>72</i>
Retention .....	73
CHAPTER 3 Country general practice: the place and the people .....	78
Landscape .....	82
History.....	91
Rural economy .....	96
Rural restructuring and development.....	98
Providing rural health care.....	101
CHAPTER 4 Methodological matters .....	110
Background.....	111
Gaining Access .....	112
<i>Finding informants.....</i>	<i>113</i>
<i>Ethical considerations .....</i>	<i>115</i>
<i>Pilot project .....</i>	<i>116</i>
Data collection .....	117
<i>Entering/leaving the field.....</i>	<i>121</i>
<i>Participant observation .....</i>	<i>125</i>
<i>Interviews.....</i>	<i>127</i>
<i>Informal discussions .....</i>	<i>130</i>
<i>Archival material .....</i>	<i>131</i>
Data analysis .....	131

<i>Interpretation</i> .....	133
<i>Rigour</i> .....	134
Limitations .....	135
CHAPTER 5 Facing changes to work practices: expectations and experiences of Australian trained male rural GPs.....	136
Feminisation of the medical workforce .....	138
Effects of health reforms on rural GPs' work practices.....	141
<i>The bureaucratic gaze</i> .....	141
<i>Competition</i> .....	145
<i>Indemnity</i> .....	148
Collegial support for rural GPs .....	149
Stress and rural medical culture .....	150
Personal relationships .....	153
'Rural practice is probably general practice at its best' .....	154
The rural GP and the local community .....	156
Future of rural general practice.....	159
CHAPTER 6 Overseas trained doctors and their spouses in country general practice .....	162
Rural medical services and the employment of OTDs .....	163
OTDs and their spouses: life and work in rural Western Australia .....	167
In their own words .....	170
' <i>Push-pull</i> ' factors attracting overseas trained doctors to work in rural Western Australia.....	170
Security .....	171
Incentives .....	172
Cultural adjustment.....	173
Isolation .....	174
Social adjustment.....	176
Professional adjustment to rural general practice .....	177
<i>Bureaucracy</i> .....	179
<i>Indemnity</i> .....	180
<i>Professional relationships</i> .....	181
The future of rural general practice .....	183

CHAPTER 7 ‘Heroes and fairy wrens’: the social practice of female rural GPs .....	186
Background .....	187
The feminisation of the medical workforce .....	189
Balancing work and home .....	193
Gender and rural general practice .....	195
<i>Female GPs’ experience of changes to rural general practice</i> .....	197
<i>Gender relations in the rural medical workplace</i> .....	199
<i>Female rural GPs’ responses to hegemonic practices</i> .....	201
<i>Multiple femininities of rural female GPs</i> .....	204
<i>Multiple masculinities of rural male GPs</i> .....	207
The future of rural general practice .....	209
CHAPTER 8 On being a ‘good’ spouse to a rural GP .....	212
Hegemonic gender relations in marriage .....	215
Reproducing hegemonic gender relations in the face of social changes .....	219
Marriages in a rural setting .....	221
The social practice of being a rural GP’s spouse .....	224
<i>Moving to a rural area</i> .....	225
<i>Conforming to hegemonic gender relations</i> .....	226
<i>The cost of conformity</i> .....	228
<i>Identity</i> .....	229
<i>Multiple femininities</i> .....	232
<i>Downsizing career aspirations</i> .....	235
<i>Resistance to structural constraints</i> .....	236
<i>Male spouses</i> .....	238
<i>Multiple masculinities</i> .....	238
The future of rural general practice .....	240
Conclusion .....	244
References .....	252
Appendix 1a .....	270
Appendix 1b .....	272
Appendix 1c .....	273
Appendix 2a .....	274

Appendix 3.....	276
-----------------	-----

## **LIST OF TABLES**

Table 1 Rural, Remote and Metropolitan Areas classification for communities: population sizes for rural and remote categories	3
Table 2 Modified RRMA classifications for population sizes and GP services in rural centres covered by the GSDGP	3
Table 3 Snapshot of the shires in the GSDGP	85
Table 4 Classification of GPs and spouses	115
Table 5 Total number of GPs working in GSDGP and total number of GPs interviewed	118
Table 6 Demographics of male GP participants	118
Table 7 Marital status of male GPs	119
Table 8 Demographics of female GP participants	119
Table 9 Marital status of female GPs	119
Table 10 Location of OTD participants	120
Table 11 Overseas trained doctors: length of time in rural general practice	120
Table 12 Location of spouses	121
Table 13 Spouses' employment	122

## **LIST OF MAPS**

Map 1 Divisions of General Practice in Australia	64
Map 2 Western Australian Divisions of General Practice	79
Map 3 Localities within the Great Southern Division of General Practice (GSDGP)	80
Map 4 Shires in the Southwest and Great Southern Region of Western Australia	81

## **LIST OF FIGURES**

Figure 1 Diagram of an index tree	132
-----------------------------------	-----

## **ABBREVIATIONS AND ACRONYMS**

ACCC	Australian Competition and Consumer Commission
ACRRM	Australian Centre for Remote and Rural Medicine
ADGP	Australian Divisions of General Practice
ADTOA	Australian Doctors Trained Overseas Association
AFGP	Australian trained female GP
AFSP	Female spouse of an Australian trained doctor
AMA	Australian Medical Association
AMC	Australian Medical Council
AMGP	Australian trained male GP
AMSP	Male spouse of Australian trained doctor
AMWAC	Australian Medical Workforce Advisory Committee
ARC	Australian Research Council
ARRWAG	Australian Rural and Remote Workforce Agency Group
CEO	Chief Executive Officer
CME	Continuing Medical Education
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
ECU	Edith Cowan University
GP	General practitioner
GSDGP	Great Southern Division of General Practice
HIC	Health Insurance Commission
HSM/DON	Health Services Manager/Director of Nursing
NESB	Non-English speaking background
OFGP	Overseas trained female GP
OFSP	Female spouse of an overseas trained doctor
OMSP	Male spouse of a overseas trained doctor
OMGP	Overseas trained male GP
OTD	Overseas trained doctor
PIP	Practice Incentive Program
PRV	Permanent resident visa
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia

RMFN	Rural Medical Family Network
RRP	Rural Retention Program
RWA	Rural Workforce Agencies
TRV	Temporary resident visa
WA	Western Australia
WACRRM	Western Australian Centre for Remote and Rural Medicine

## INTRODUCTION

An Australian Commonwealth Government report titled *Rural, Regional and Remote Health: Indicators of Health* released in May 2005 confirmed findings from the 1998 report *Health in Rural and Remote Australia* that proportionately more Australians living in non-metropolitan areas suffer from serious disease, illness and injury than those living in metropolitan areas. The further the distance from a metropolitan area, the higher are the rates of morbidity and mortality. Both reports also found disease and illness often relate directly to socio-economic factors such as living conditions, social isolation and distance from health services (Phillips, 2005; Strong, Trickett, Titulaer, & Bhatia, 1998).

Health care services in rural Australia are inadequate not least because rural locations do not have the range of services available in metropolitan centres. Difficulties attracting and retaining rural health professionals, and not just doctors, compound the problem (Australian Institute of Health and Welfare, 2002; Strasser, Hays, Kamien, & Carson, 2000; Strong et al., 1998). Nor is this problem confined to Australia. New Zealand, Britain, the United States and Canada have also experienced problems recruiting health professionals to work in rural areas (Easton, 1997; Hays, 1999; McAvoy, 2000-2001; O'Reilly, 1997). Challenges rural health professionals face include the 'tyranny of distance', isolation, limited professional support and a loss of services such as banking and education that have affected 'a significant element of community vitality and prosperity' (Cocklin & Alston, 2003: 2).

Medicine is one of the most pre-eminent and prestigious professions in Western industrialised societies. Medical practitioners are considered expert authorities in matters related to health and disease, a position secured and maintained by support from successive governments (Freidson, 1970; Germov, 2003a). Alternative service models of health care delivery, such as public health initiatives to improve quality of life, have made little leeway into the dominant

position held by general practitioners (GPs) in rural communities (Smith et al., 2004). A medico-centric approach to health has been so successful in influencing community beliefs that Australians view rural health problems primarily as those of doctor shortages and hospital closures with only muted discourse on other ways to provide health care (Palmer & Short, 2000). The Australian Medical Association (AMA) (2001a: 4) sees providing ongoing medical services as essential for rural communities.

## **Rural general practice**

This study centres on the area covered by the Great Southern Division of General Practice (GSDGP) in rural Western Australia.<sup>1</sup> The project resulted from negotiations between the Centre for Social Research at Edith Cowan University (ECU) and the GSDGP. The GSDGP, as the Industry Partner, assisted the Australian Research Council (ARC) to provide funding for ECU to carry out the project. Rural GPs and their spouses are the focus of the investigation. ‘Rural’ is a contested term with various definitions embracing socio-demographic characteristics such as population density, different types of land use and socio-cultural factors reflecting social relationships and values. Such definitions have been criticised for their limited perspectives where arbitrary representations of the notion of rural paint an inaccurate picture of differences in land use or even between rural and non-rural (Black, 2005). For economy of expression, this thesis will use the term ‘rural’ to designate non-metropolitan areas. The diversity between rural locations is also acknowledged and requires further explanation. To differentiate between metropolitan, rural and remote locations, the Department of Primary Industries and Energy and the Department of Human Services and Health published the Rural, Remote and Metropolitan Areas (RRMA) classification for population sizes in 1994. The RRMA system classified remoteness based on 1991 population Census data and Statistical Local Area (SLA) boundaries. It divided geographic areas into three zones: metropolitan, rural and remote and has been used as a proxy for access to health services (see Table 1):

---

<sup>1</sup> The role of the Divisions of General Practice will be explained later in the thesis.

**Table 1: Rural, Remote and Metropolitan Areas classification for communities: population sizes for rural and remote categories**

<b>Rural Remote and Metropolitan Areas (RRMA) classification</b>	<b>Population size</b>
<b>RRMA 3</b> large rural cities	25 000 – 99 999
<b>RRMA 4</b> small rural centres	10 000 – 24 999
<b>RRMA 5</b> other rural centres	< 10 000
<b>RRMA 6</b> remote centres	> 5000
<b>RRMA 7</b> other remote centres	< 5000

Source: (Department of Primary Industries and Energy & Department of Human Services and Health, 1994: 4)

The RRMA classification system is currently under review. The review aims to develop a better system that takes into account geographic data as well as workforce shortages and issues related to the health and wellbeing of a region (Australian Department of Health and Ageing, 2005). However, while the RRMA classification system has been contested and is open to ongoing debate, a modification of it is suitable for use in this thesis. For the purposes of this study, distinctions are made between large, medium and small rural centres according to population size and number of GPs practising in each location in the GSDGP (see Table 2). A non-metropolitan centre with a population of over 20 000 with several general practices serving the community is termed a large rural centre. A town with a population between 4000 and 19 999 serviced by one or more group general practices is classified as a medium rural centre. A small rural centre denotes a population under 4000 where a solo GP provides medical services.

**Table 2: Modified RRMA classifications for population sizes and GP services in rural centres covered by the GSDGP**

<b>Classification</b>	<b>Large rural centre</b>	<b>Medium rural centre</b>	<b>Small rural centre</b>
<b>Population</b>	>20 000	4000-19 999	<4000
<b>General practices</b>	8 group 1 solo	6 group	8 solo

Recruiting and retaining GPs is a high priority on the Commonwealth government's rural health agenda (Australian Government Department of Health and Ageing, 2004). For the last 20 years, research into the provision of medical services in rural areas has found that Australian trained doctors are often reluctant to leave the cities (Boffa, 2002; Kamien, 1987). In an increasingly

uncertain social, political and economic climate in which health professionals now work, the decision to move to rural general practice may seem unattractive for many GPs and their spouses,<sup>2</sup> given their professional or employment aspirations and their children's educational needs. Consequently, some towns and regions are unable to recruit GPs at all while in others GPs and their families are adversely affected by the conditions under which they are expected to live and work (Strasser et al., 2000; Strasser, Kamien, & Hays, 1997).

Various solutions to the problem have been proffered. The *Medicare Plus* package, introduced by the commonwealth government in 2004, includes a commitment to improve medical services by training more doctors in Australia. But this strategy is long-term. For now, Commonwealth, state and local governments are offering generous incentives to assist GPs and their families in the hope of attracting them to rural areas so they will want to stay. Incentives include subsidised relocation grants, accommodation, opportunities for continuing medical education and locum assistance (Australian Rural and Remote Workforce Agencies Group, 2003-2004; Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002). Overseas trained doctors (OTDs) are being employed to address the immediate problem and provide services in locations unable to attract Australian trained doctors (Australian Government Department of Health and Ageing, 2004; Australian Medical Workforce Advisory Committee, 2004b; Donovan, 2003; Roach, 2003).

A report to the Australian Health Ministers' conference from Australian Health Care Agreement Reference Groups in 2002 argued that, despite efforts to improve recruitment and retention, the 'rural health and aged care system continues to fall behind in providing access for local rural communities to comprehensive, appropriate health and aged care services' (Australian Health Care Agreement Reference Groups, 2002: 54). Some researchers argue that the sickest people, including those from low socio-economic groups and Aboriginal communities who need medical care the most, often have great difficulty accessing services. A contributing factor to rural shortages is medical

---

<sup>2</sup> I use the term 'spouse' to include personal partners of GPs who are not married to each other.

practitioners preferring to live and work in areas of higher socio economic status (Boffa, 2002). A report commissioned by the Australian Medical Association in 2001 predicts even greater shortages of rural GPs (Access Economics, 2002); thus a deeper enquiry into the problem is warranted. Evidence suggests that rural general practice is in transition, which is creating an air of uncertainty and frustration amongst rural GPs (Strasser et al., 1997; Wainer, 2002). Factors contributing to that uncertainty and frustration need examination.

Most research on recruitment and retention has centred on the relationship between GPs and the rural environment in which they live and work and has examined issues such as the effects of isolation, the lack of services, and limited professional, occupational and educational opportunities (Strasser et al., 1997; Wainer, 2002). Proffered solutions to such difficulties have included providing locum relief, financial incentives, and better housing and working conditions (Humphreys & Rolley, 1998; Strasser et al., 2000; Strasser et al., 1997). While a rural setting cannot always meet the professional and lifestyle expectations of GPs and their spouses, keeping the solutions centred on the needs of individual GPs and their families, or on the disadvantages of rural 'space', works against critically examining the issue within a broader social context. By opening up the discourse to analyse the relationship between structural factors and social practice, this thesis expands the parameters within which to view the problem and consider innovative solutions. The thesis demonstrates how structural factors impact on the social practice of rural GPs and their spouses. More specifically, it examines how gender relations and political and economic structures affect the actions, expectations and experiences of rural GPs and their spouses. This approach locates recruitment and retention in a broader social context and offers a more nuanced understanding of this complex issue.

There are many definitions of structure in a social context.<sup>3</sup> I draw on Connell's (1987: 92, 107) notion of social structure as the recurring pattern of social relations that is informed by a complex interplay of power evident in relationships within and between social institutions. Power is diffused through

---

<sup>3</sup> I use the terms 'structure' and 'social structure' interchangeably.

these institutions such as the State,<sup>4</sup> the health system and the family and can manifest in ideas about social relations that are reproduced to support dominant groups. At one level, social structure conditions social practice and lies beneath ‘the surface complexity of interactions and institutions’ (Connell, 1987: 93), providing a ‘template’ for how people relate to each other. At another, social structure acts to constrain behaviour or practice that deviates from the norm. In each of these ways, there is a relationship between structure and social practice.

Connell (1987) suggests that social institutions are informed by a range of beliefs and practices that underpin power relations and help explain the possibilities and constraints for social practice and their consequences. This ‘structure’ of power is evident when considering gender relations. Gender as a structuring or organising principle in social relations permeates all institutions including the family, the workplace and the State. Power relations are also present in political and economic structures that act as organising principles guiding social practice. Connell (1987: 62) argues that the ‘structure’ conditions practice. Social practice reflects how people constitute their social relations in light of structural principles or general rules that guide action, expectations and experiences. Thus, the social structure informs the interpretation and practice of masculinity and femininity, reflecting the ‘norm’ of gender relations in specific contexts (Connell, 1987: 120). In other words gender is something that is ‘done’ in social life rather than something that is abstracted from it (Connell, 2002: 55). Political and economic structures ‘guide’ the action, expectations and experiences of the medical and health professions. Structures endure because they are reconstituted daily in social action.

While structures are reproduced in social practice, they can also be contested. Social action or practice can impact on structure and this process suggests that there is ‘an active presence of structure in practice, and an active constitution of structure by practice’ (Connell, 1987: 94). While structures can constrain practices that deviate from the norm, individuals or groups can resist

---

<sup>4</sup> In this thesis, the noun ‘State’ (with a capital ‘S’) refers in a generic way to the institutions of government in Australia. The noun ‘state’ (without a capital letter) refers to a sub-national region such as Western Australia or Victoria.

recurring patterns of social relations that do not serve their interests. This resistance can lead to conflict and generate tension with those who support such patterns. However, from this tension, changes to those patterns can emerge whereby older structures are replaced by newer ones. This process suggests a dialectical relationship between those who support the structure and those who resist it.

Whilst recognising the contested nature of the term ‘dialectic,’ I define a dialectical relationship between structure and social practice as a relationship in which ideas or practices that oppose each other cause tension that can lead to changes either in the structure or in social practice. More specifically, I use the term ‘dialectical relationship’ when referring to relationships between GPs, between GPs and their spouses and between GPs and other groups where the social practice of groups or individuals may oppose dominant or recurring patterns of social relations. This can generate tension between individuals or groups that can also lead to changes to those patterns. A dialectical relationship can also occur when structural elements oppose the social practice of groups not conforming to the norm. This, too, can cause tension that can lead to changes in the social practice of such groups.

Many scholars from Socrates to Hegel and Marx interpreted and used the term dialectic in various ways to convey, among other things, the notion of tension that exists in a debate when opposing forces or ideas meet. Murphy analyses dialectical theories and draws on the Hegelian notion that:

[T]he structure of reality is a structure of oppositions, of elements that contradict each other and limit each other’s possibilities. Out of this clash of antagonistic tendencies, new forms arise that incorporate the opposing elements, albeit in altered form and with their contradictions now resolved (Murphy, 1971: 95).

Murphy explains that the issues or patterns that conflict with each other cause tension. Within that tension, limitations can be reinforced or transcended. Limitations are transcended when forces that oppose each other intersect and allow a process of change to occur. Thus new ideas and ways of being may emerge.

I argue in this thesis that a dialectical relationship can exist between social structure and social practice. This is evident in the context of rural general practice whereby the social practice of at least some rural GPs and their spouses may oppose recurring patterns within the social structure that do not serve their interests. While their resistance may cause conflict and tension, it can also lead to change. I focus particularly on gender relations and political and economic factors as structural influences affecting social practice. My rationale for choosing these factors over others is twofold. First, at the beginning of the project I sought to examine the extent to which political and economic changes affect the autonomy and control of rural GPs over their work practices. Second, after analysing my findings it became clear that these factors were not the only structural element worth investigating. Gender relations emerged as a driving force affecting social practice in the workplace and in the home. This was evident in GPs' and their spouses' expectations and experiences related to the division of labour, work practices, roles within the family and the community, and recruitment and retention. As a result, the issue of gender relations developed into a central theme in the thesis. Structural factors can influence social practice and can lead to changes to practices that deviate from the norm. By the same token, social practice can also impact on the structure so that it changes.

At least potentially, GPs and/or their spouses have the choice and capacity to resist structural limitations that conflict with their own interests. At the level of practice, tension generated as they respond to limitations often reveals the struggle between conflicting forces and ideas that has the potential to create change. A case in point is female GPs who challenge the work practices of male GPs by demanding more flexible hours. Such a challenge conflicts with conventional notions of medical work practice that have often supported a male model of work patterns espousing long working hours (Pringle, 1998). This model is particularly evident in rural general practice. Female medical practitioners, many of whom are the main caregivers in the home, are generally calling for changes to the long hours they work that make it difficult to achieve a balance between work and home life (Pringle, 1998; Wainer, 2000; Witz, 1992). While their calls for change undoubtedly cause tension amongst their colleagues, they also sow the seeds for change where limitations embedded in conventional

work practices can be transcended to allow new ideas and practices to emerge, an issue discussed later.

The thesis examines the effect of specific structural issues on the social practice of rural GPs and their spouses and on their decision to remain in rural general practice. It draws on theoretical ideas and ethnographic data to provide the framework. The thesis presents its ethnographic findings using discrete chapters to identify responses from different groups of participants to specific themes that are repeated in each chapter. A case in point is the increasing feminisation of the medical workforce and its effects on participants' expectations and experiences of rural general practice. Such a framework allows themes emerging from the data to be examined for similarities and differences within and between groups. This approach permits a more nuanced analysis of factors affecting participants' decisions as to whether they remain in a rural area. It reveals the role social structure plays in influencing the interests of discrete groups that either reproduce or contest enduring patterns of social relations. In this way layers of meaning and understanding emerge that reflect both the complexity of the issue of recruitment and retention and the dialectical relationship between structure and practice. As groups struggle to assert their respective interests in the face of the so-called norm, conflict may occur. However, tension generated within such conflict has the potential to lead to change.

Some studies on recruitment and retention have overlooked the influence structural factors have on social practice and their part in changing the face of rural general practice. The role of gender is important when considering rural GPs' and their spouses' expectations and experiences at a professional and personal level. Historically, rural general practice was often seen more as a vocation and less as a job as GPs heroically worked long hours to meet their patients' demands (see also Fowlkes, 1980; Strasser et al., 1997). Tension created by more women entering the medical workforce who contested conventional models of work practice in favour of flexible working hours is leading to change. Recent British research indicates that some male GPs are also opting for more flexible work patterns (Young, Leese, & Sibbald, 2001). However, limited studies are available on the expectations and experiences of

spouses of rural GPs in the face of structural changes, a theme explored in this thesis.

## **The social practice of gender**

### ***Female rural GPs***

Since the 1980s, the number of women entering the medical profession in Australia has been increasing (Australian Institute of Health and Welfare, 1999a). In the late 1990s, for the first time, over 50 per cent of the medical student intake were women (Australian Institute of Health and Welfare, 1999a). Predictions that women entering medical school will increase from 53 per cent in 1999 to 60 per cent in 2010 support this trend with estimates suggesting that, proportionally, women entering the GP training program could increase from 58 per cent in 1998 to 65 per cent in 2010 (Australian Medical Workforce Advisory Committee, 2000). While studies show that female medical practitioners are more likely to work in metropolitan centres than rural locations (White & Fergusson, 2001), women currently make up over 50 per cent of young doctors training for rural general practice (Wainer, Bryant, & Strasser, 2001) and over 60 per cent of the rural registrar intakes (Wainer, Strasser, & Bryant, 2005).

Compared to their male colleagues, female GPs have generally embraced a different work ethic. Many resist long working hours and prefer to work part-time and spend longer time with patients (Pringle, 1998; Wainer et al., 2001). This suggests a dialectical relationship whereby their ideas and practices conflict with a male model of rural general practice, opening the possibility for change. Part of the reason women medical practitioners prefer working fewer hours is that they shoulder most of the responsibility for childcare and home-making (Lippert & Tolhurst, 2001; Wainer, 2004). Their wishes to better balance the demands of work and home are impacting on medical work practices, often causing conflict and tension but are also paving the way for change (Beagan, 2001; Pringle, 1998; Wainer, 2003).

Structural constraints are illustrated in the dilemma for many female medical practitioners who want to fulfil their role as main caregiver in the home, while at the same time meet the demands of their role in the workplace. Recent research in Australia suggests that, while interest in men's involvement in

childcare may be increasing, at least in theory, as popular support for the traditional sexual division of labour is on the wane, this shift is not reflected in practice. Instead, conventional models of gender roles persist where men's priority is to be the breadwinner and women are cast as the main caregivers (Bittman, Hoffman, & Thompson, 2004). In 1997 older males made up the majority of the rural general practice workforce (Strasser et al., 1997), and recent figures show that the ageing trend is continuing where the average age of the overall medical workforce in 2002 was 46.6 years compared to 44.9 years in 1996 (Australian Medical Workforce Advisory Committee, 2004a). In 1996, 21.8 per cent of medical practitioners were over 55 years compared to 23.7 per cent in 2002. Numbers of female medical practitioners have risen from 27.2 per cent in 1995 to 31.6 per cent in 2002 (Australian Medical Workforce Advisory Committee, 2004a). Trends in current medical workforce participation suggest that by 2010, women will comprise 41 per cent of the GP workforce (Australian Medical Workforce Advisory Committee, 2000). In 2001, 44.3 per cent of medical practitioners worked more than 50 hours per week (Australian Medical Workforce Advisory Committee, 2004a). A higher proportion of rural GPs worked over 50 hours a week compared to their metropolitan colleagues (Australian Government Department of Health and Ageing, 2004: 122). Working long hours is not sustainable for female GPs who are the main caregiver in the family. Findings from the *National Rural General Practice Study* (NRGPS) cautioned against maintaining current models of work practice when developing programs and policy because the rural medical workforce is changing (Strasser et al., 1997). This factor must be considered seriously when planning future rural health services.

### ***Rural GPs' spouses***

GPs seldom live alone while working in rural locations. Kamien (1987: iv) argues that spouses often play a significant role in determining whether the GP stays or leaves a rural community, claiming that the 'success and retention of a doctor depends to a large extent on the adaptability of the spouse'. Yet most studies on recruitment and retention have focused mainly on GPs' needs with far fewer addressing those of their spouses. This study identifies and analyses the needs of both rural GPs and their spouses.

Australian researchers have argued that barriers to recruiting and retaining rural GPs include the lack of employment, education and training opportunities for GPs' spouses (Nichols, 1997; Wise, Nichols, Chater, & Craig, 1996). This perspective is, however, only part of the story. Gender roles in rural medical marriages/partnerships also need examining when considering GPs' spouses' needs. Studies on the recruitment and retention of rural GPs often adopt an uncritical approach to the significance of gender in rural medical marriages/partnerships. An implicit assumption prevails that the division of labour in the home falls within conventional parameters with male as provider and female as the primary caregiver. Many female spouses of rural GPs adopt the role of caregiver and, if they are in paid employment, often work in their spouse's general practice. Male spouses of rural GPs, on the other hand, seldom work within the practice and are more likely to be employed in their original profession (Wise et al., 1996). Male and female spouses' different expectations and experiences are explored later in the thesis. They are set against a backdrop of the dialectical relationship between structure and social practice that is played out in some rural medical marriages/partnerships.

Examining issues related to recruitment and retention from a broader, structural perspective allows a deeper analysis of the frustration many rural GPs experience in the face of social changes. Political and economic changes are not only impacting on their work practices but also on the restructuring and development of rural communities in which GPs and their families live and work.

## **The effects of political and economic change**

### ***Rural centres***

Political and economic changes in the last 20 years have significantly affected those living in rural locations. The positive and negative effects of economic reform are juxtaposed with increasing morbidity and mortality rates for those living in rural areas (Phillips, 2005). Since the mid-1980s the Australian Labor and Coalition governments have shifted policy direction by embracing neoliberalist principles. There has also been a distinct move away from support for the welfare state, with its focus on social protection, towards an increasing

emphasis on competition and cost containment in social policy, such that market forces tend to drive resource allocation (Palmer & Short, 2000; Rodger, 2000; Twaddle, 1996). Economic reform has resulted in less State assistance to rural and farm sectors. Increased use of technology and mechanisation in agriculture has led to out-migration as less labour is required (Haslam McKenzie, 2000). Added to this, essential services such as banking have been withdrawn in many small towns (Tonts, 2000) and those living in rural locations are incurring higher costs to access face to face financial services (Argent & Rolley, 2000). The effects are most keenly felt in the least densely populated areas (Tonts, 2000). Indigenous communities are hardest hit with 16 per cent of Indigenous people living more than 80 kilometres from a bank, and 15 per cent living more than 80 kilometres from a hospital compared to one per cent of non-Indigenous people (Haberkorn and Bamford cited in Larson, 2002: 7). It is within an overall context of rural decline that GPs are being recruited to work in rural locations. The next section indicates that political and economic changes have also affected the health industry including rural medical services.

### ***Rural health services***

Governments in Australia consider the pursuit of economic efficiency and growth as a more secure route to social wellbeing than is political regulation or intervention (Black et al., 2000). Given that an emphasis on competition and cost efficiency has led to reduced access to services in some rural locations it is hard to fathom how the health of rural communities has benefited from these reforms. Rodger (2000) asks how can the most vulnerable be protected from the vagaries of the global economy that prioritises economic rather than social needs? Indeed, a substantial body of evidence points to poorer morbidity and mortality rates among those living in rural locations compared to their urban counterparts, a differential reinforced by current social welfare policies (National Rural Health Policy Forum & National Rural Health Alliance, 1999-2003; Phillips, 2005). These findings point to the need to reassess what constitutes 'equitable' health care and how best to meet that demand.

The medical profession has long dominated the health division of labour 'economically, politically, socially and intellectually' (Willis, 1989: 2).

Currently, doctors continue to exercise authority over other health occupations and shape society's beliefs about health problems and how they should be managed, all of which have important implications for health policy (Germov, 2003a). Yet the position of power held by the medical profession in health care is under scrutiny and is less assured in light of structural changes. While the market place has been deregulated, many doctors complain that the government is increasingly regulating their work (Strasser et al., 1997); thus, they are held increasingly accountable for their actions. Rapid technological change has also made them vulnerable to government surveillance of their work patterns (White, 2000a). Such changes are to some extent undermining their historic autonomy and control of clinical practice, creating insecurity and frustration.

Other structural factors have also created uncertainty in the rural medical workforce. Historically, the Australian system of health care has been based on a philosophy of health care being associated with medical care (Humphreys, 1998; Palmer & Short, 2000; Willis, 1989). Indeed, rural people prefer to access a GP as the first point of contact for any health problem (Strong et al., 1998). Yet when attempts to recruit and retain rural GPs fail, nurses often fill the gap as primary health care practitioners (Duckett, 2004; Pearson, 1993). In the prevailing political and economic climate, health services have undergone significant and rapid changes with various occupations contracting or extending the boundaries of their roles. This has led to health professions often competing to provide services once offered only by the medical profession (Pearson, 1993). Such changes are undermining the authority and control of the medical profession in some contexts, and have caused tension amongst medical practitioners (Strasser et al., 1997; Wainer, 2002). Health policies in Australia have generally maintained a medico-centric focus designed to induce more doctors to practise in rural areas, giving relatively little attention to possible alternative approaches to rural health service delivery (Palmer & Short, 2000). Such a response makes it difficult to implement innovative solutions outside that medico-centric paradigm. Approaching the issue from the broader context of health improvement, the diversity in health care needs among rural communities can be examined, and innovative solutions considered, rather than providing a 'one-size-fits-all' response (Keleher, 1999).

## **Purpose of the study**

This research provides a broader, sociological lens through which to view factors affecting the recruitment and retention of the rural GP workforce. Previous studies have focused on the needs of GPs, identified the disadvantages of rural general practice and examined the relationship between rural GPs and their immediate environment. This project locates GPs' *and* their spouses' expectations and experiences in the context of structural change to understand more deeply the complexity of factors that affect the supply of rural GPs.

Using ethnographic methods, the study examines the effects of structural changes, specifically gender relations and the political and economic climate, on the expectations and experiences of rural GPs and their spouses living and working in the area covered by the Great Southern Division of General Practice in rural Western Australia. It seeks to understand how such changes influence social organisation and are experienced at the level of practice. The study also considers GPs and their spouses/partners as a 'unit' when discussing issues related to recruitment and retention. Given that many rural centres are drawing heavily on overseas trained doctors (OTDs) to maintain the rural general practice workforce, factors underpinning their choices to work in rural Australia, and their decision to stay or leave, are also considered. OTDs and their spouses, many of whom come from culturally and linguistically diverse backgrounds, inevitably bring with them aspirations that may not adequately be fulfilled in a rural Australian location. Rarely has research focused on this group's experiences and expectations of rural general practice and country living. This study fills that gap.

The project will contribute to a growing body of research forging fruitful dialogue between social scientists, medical practitioners, government, and industry or community groups. Findings from this study will be made available to national and local agencies such as Divisions of General Practice and University Departments of Rural Medicine. The findings will also assist the Industry Partner involved in the project, the GSDGP, to improve its services and support structures for the GPs it employs. The Industry Partner may also use the results to contribute to debate about strategies to attract and retain general

practitioners to work in rural locations and thus to improve the quality of rural health and medical services.

### **Areas of enquiry**

The dialectical relationship between structure and social practice underpins this enquiry to allow a broader, sociological analysis of the expectations and experiences of rural GPs and their spouses to emerge. Questions generating the enquiry are:

- What factors contribute to the decision made by GPs and their spouses to live and work in a rural location?
- To what extent do the conditions under which GPs and their spouses live and work influence their decision to stay in or leave rural general practice?
- Might difficulties in attracting and retaining GPs and their spouses lead us to consider other ways to provide health services to those living in rural locations?

### **Chapter overview**

The first four chapters of the study provide a backdrop within which to locate the findings from this ethnographic research. Chapter One introduces the social context of the project by examining changes in Western industrialised countries that have impacted on the dominant role of the medical profession and the delivery of rural medical services in the last 30 years. It focuses on concepts of power to examine how enduring patterns of social relations are either reproduced or contested. The role played by political and economic factors and gender relations in a rural general practice setting is significant. It demonstrates the importance of structural influences on the expectations and experiences of rural GPs and their spouses, a theme given limited consideration in other research on recruitment and retention. The ideas of Antonio Gramsci and Pierre Bourdieu help to explain notions of power embedded in structural factors that affect social practice whilst also revealing the concept of resistance when dominant ideas are contested. Research by Robert Connell, Rosemary Pringle and Ken Dempsey extends these explanations to include gender relations

generally, and in a medical context and a rural setting more specifically. The work of critical medical anthropologists and sociologists, including Hans Baer, Merrill Singer and Kevin White helps to locate the effect on medical practitioners of wider social changes that impact on their autonomy and control in a work setting.

Chapter Two presents a more specific explication of research on recruiting GPs to work in rural locations and on retaining their services. It provides a background to some of the policies related to the delivery of rural health services that indicate their medico-centric focus. These include an increasing emphasis on attracting OTDs to work in rural areas of need where GP positions are not filled by Australian trained medical practitioners. Chapter Three takes the reader on a journey through the area covered by the Great Southern Division of General Practice in rural Western Australia that is the focus of this research. The aim is to convey not only the sense of isolation and distance between the rural towns in which GPs and their spouses live but also their diversity that questions the notion of 'rural' as a homogeneous concept. The diversity is reflected in the historical, social and economic developments that impact on health service delivery and issues related to recruitment and retention of GPs. Chapter Four sets out the methods used to gather information, access participants, organise and conduct interviews, manage and store information and analyse the findings.

The final four chapters submit the findings of the research. Each starts with information specific to the focus of the chapter that locates it in a wider social context. The main content of each chapter presents findings based on interviews with GPs and their spouses. Participants' own words are used to illustrate the themes emerging from their responses and to reveal the dialectical relationship between structural elements and social practice in the medical workplace and the home. Chapter Five examines the expectations and experiences of Australian trained male GPs living and working in rural locations. Political and economic changes and the increasing feminisation of the medical workforce are affecting GPs' autonomy and control of their work practices and are changing the face of rural general practice. Despite this, most GPs enjoy working in a rural area and plan to stay. Chapter Six focuses on the lives of

overseas trained doctors working in rural locations, specifically addressing some of the cross-cultural challenges they face and how these affect enjoyment of their work and living conditions. Chapter Seven considers how dominant ideas about gender relations affect social practice and focuses on female rural GPs, many of whom balance the demands of work and home. It also examines how female rural GPs' expectations and experiences of their work practices intersect with, and affect, those of their male colleagues. The final chapter explores the challenges faced by spouses of rural GPs and the different expectations and experiences of male and female spouses in light of hegemonic beliefs regarding gender relations.

The conclusion draws together reasons why this study is important. It notes that, while research into attracting and retaining GPs in rural areas is not new, the focus has often centred on the expectations and experiences of the GP. While this study acknowledges commonalities in findings with previous research, it broadens the parameters in which to view the problem by probing more deeply into factors influencing the provision of rural GP services. It also foregrounds the role of rural GPs' spouses and seeks to understand how their expectations and experiences influence decisions to stay or leave rural general practice. The study's findings show that critically examining the relationship between broader structural issues and social practice offers a more nuanced appreciation of the range of factors that affect the lives and work practices of GPs and their spouses in rural locations. This in turn has implications not only for the recruitment and retention of rural GPs but also for other aspects of the delivery of health care in rural areas.

## CHAPTER 1

### **The changing face of rural general practice: the relationship between structure and social practice**

Dramatic social changes in the last 40 years have affected rural general practice. Growing numbers of women are entering the medical profession (Pringle, 1998; Wainer, Bryant, Strasser, Carson, & Stringer, 1999), government regulation in the area of medical practice is increasing (Carson & Stringer, 1998), non-medical health professionals are competing to provide services historically offered only by the medical profession, and patients as health ‘consumers’ are calling for more accountability from medical practitioners for their actions (Germov, 2003a). The questions raised in the context of rural general practice are the extent to which such changes have affected rural GPs’ work patterns and have influenced choices they and their spouses make to remain in a rural area.

To answer these questions I locate the lives and work practices of rural GPs and their spouses in the context of wider social relations to seek to understand factors influencing their responses. More specifically, I examine the dialectical relationship between structure and social practice in different contexts. Changes to work practices are occurring as increasing numbers of women enter the workforce and government policy shifts direction away from social welfare towards an economic emphasis on competition and cost effectiveness. I focus particularly on gender relations and political and economic factors as major structural principles impacting on the actions, expectations and experiences of rural GPs and their spouses.<sup>5</sup>

Ortner’s (1989: 13) research found that ‘practice is inextricably tied to the notion of structure’. The dynamic nature of this relationship is revealed when changes to social structure affect social practice, and changes in social practice have the potential to alter the recurring patterns of social relations rather than just

---

<sup>5</sup> Giddens (1986: 185) uses the term ‘structural principles’ to denote principles that underlie social organisation.

reproduce them. A case in point is an heroic work ethic influencing work patterns in rural general practice. Historically, rural doctors' long working hours have allowed little time at home. Many female medical practitioners are choosing to work fewer hours, often to balance the demands of work and home (Pringle, 1998; Wainer, 2004). Their interests conflict with the 'norm' in calling for structural changes in the medical workplace. Rather than reproduce the conventional work ethic, female medical practitioners are resisting it. While not all female GPs support this move, nor male GPs resist it, a dialectical relationship is revealed when calls for structural changes lead to a struggle between those supporting conventional ideas of work practices and those contesting them. Tension generated from this struggle has, in some instances, successfully led to change. Some male medical practitioners are now also opting to work fewer hours (Pringle, 1998; Young et al., 2001).

To examine the dialectical relationship between structure and social practice I initially draw on particular themes in the works of Gramsci (1999) to provide a theoretical framework to understand factors affecting the expectations and experiences of rural GPs and their spouses. I also identify specific ideas in Bourdieu's (1989; 2004; 1977; 2002) extensive body of work that offer a more nuanced perspective to appreciate how enduring patterns of social relations are reproduced or are contested and sometimes changed. The chapter then addresses the notion of a dialectical relationship more specifically. First, it examines Connell's (1987; 2002) work on gender relations and the research of Pringle (1998) and others to focus particularly on gender relations in a medical setting. Dempsey's (1990; 1992) work offers a more specific explanation of gender relations in a rural setting. Second, it draws on the work of critical medical anthropologists Baer (1986), Singer (1990; Singer & Baer, 1995) and others to examine the effects of political and economic changes on rural general practice. The chapter explores these themes further in light of previous research on social changes by reviewing literature on gender relations in the workplace and the home and the effects of political and economic change on medical practice, rural restructuring and development, and the provision of rural medical services. The chapter starts by providing a theoretical backdrop in which to locate the

relationship between structure and social practice by examining the idea of power in recurring patterns of social relations. It begins with the notion of hegemony.

## **Hegemony**

The basic premise of Gramsci's theory of hegemony is that we are not ruled by force alone but also by ideas (Bates, 2002: 247). Hegemony is a relationship of power where one social group or class, through their position of leadership and cultural dominance, exercises power over subordinate groups in various ways (Forgacs, 1988: 306-307). According to Gramsci, the State, made up of public institutions such as the government, the judiciary and the police, embodies the ideas of the dominant social group or ruling class; these institutions are used to legally enforce those ideas on civil society, regardless of the wishes of those who make up civil society (Bates, 2002: 247; Forgacs, 1988: 306-307; Gramsci, 1999: 12). Gramsci describes civil society as 'private' institutions such as the family, trade unions and the church. In his opinion, dominant groups in civil society use these institutions in order to promote their ideas and gain the consent of subordinate groups. Thus, a consensual reality is formed when subordinate groups agree with the ideas, values and beliefs put forward by a dominant group to the extent that such ideas are accepted as the norm or common sense. In this way dominant groups, aided by social institutions reinforcing their ideas, are able to direct social and political consciousness (Bates, 2002: 247; Gramsci, 1999: 12). Gramsci (1999: 12) argues that subordinate groups 'spontaneous[ly] consent' to the norms of social life espoused by dominant groups. This occurs because a dominant group holds power and leadership positions within the social order:

...the entire complex of practical and theoretical activities with which the ruling class not only justifies and maintains its dominance, but manages to maintain the active consent of those over whom it rules (Gramsci, 1999: 244).

However, a dominant group needs to win support for its ideas to strengthen its power base. Developing alliances is central to the 'organisation of consent' (Simon, 1982: 21). The dominant group forms alliances with other groups by considering their interests and combining them with its own thereby

strengthening its position (Gramsci, 1999: 60; Simon, 1982: 23). One result of this process is that subordinate groups see the ideas of a dominant group supporting the common good in a way that reflects ‘a deeply held belief that the superior position of the ruling group is legitimate’ and that ‘the hegemonic group stands for a proper social order in which all men [*sic*] are justly looked after’ (Femia, 2002: 266). People are more likely to agree to the dominant group’s ideas if they fit their notion of ‘common sense’ or conventional wisdom regarding social practice. Thus, hegemony is a relation ‘not of domination by means of force, but of consent by means of political and ideological leadership. It is the organisation of consent’ (Simon, 1982: 21).

Gramsci (1999: 196-197; Simon, 1982) also maintains that people’s notion of common sense, or the way they perceive the world in which they live, is generally unreflective and uncritical. Each individual tends to see the social order as a given, rather than something that has been socially constructed. Williams (1994: 596) explains that subordinate classes are conscious only of the ideology of the dominant class because, axiomatically, the dominant class defines and controls the production of ideas. In other words, ideas serving the dominant group’s interests are reproduced when subordinate groups accept such ideas as the norm.

Gramsci describes hegemony as more than just an ideology in that it exists also in practice. It goes beyond ideas and beliefs to encompass a ‘whole social process’ that interlocks ‘political, social and cultural forces’ that impact on social practice (Williams, 1994: 595). According to Williams, the hegemonic process involves the relationship between ideas and their implementation as practice. It entails:

... a whole body of practices and expectations over the whole of living, our senses and assignments of energy, our shaping perceptions of ourselves and our world. It is a lived system of meanings and values - constitutive and constituting - which, as they are experienced as practices, appear as reciprocally confirming (Williams, 1994: 596).

Gramsci developed his work from within a Marxist framework as a form of class analysis within a distinct historical period. I take some of his insights and

situate them in a contemporary setting. I use the concept of hegemony to indicate the relationship between dominant groups such as the male rural GPs and subordinate groups such as female rural GPs and female spouses of rural GPs. This relationship is influenced by structural principles, or the general rules that guide action, played out in social practice. However, ideas supporting the dominant group's interests that are accepted as the norm by subordinate groups can also be contested. Such resistance implicitly questions the notion of whose interests the so-called 'common good' is effectively serving. Thus, counter-hegemony may also be evident at the level of social practice. Subordinate groups may form alliances to resist, and sometimes usurp the position and ideas of the dominant group (Gramsci, 1999: 77-78). This process illustrates a dialectical relationship whereby subordinate groups who want to pursue their respective interests may, in the process, contest recurring patterns of social relations and cause tension in the relationship with the dominant group. In other words, social practice may resist structural elements and create the potential for change to such structures in some contexts.

In a contemporary medical context the majority of rural GPs have, for many years, been male. They have held a dominant role, supported by the State, in the delivery of health services. Their work practices have involved long hours (Australian Government Department of Health and Ageing, 2005: 105, 121-122). Most male GPs are married and their spouses have adopted the primary caregiving role in the social organisation of the family and have supported the work of their GP partners (Nichols, 1997; Wise et al., 1996). Female medical practitioners have also sustained the dominant group's interests by fitting in with its ideas regarding work practices despite many female medical practitioners also being the main caregivers in their families (Bryant, 1997; Crompton & Le Feuvre, 2003; Lapeyre, 2003). However, as their numbers grow in the medical workforce, many women are contesting inflexible work patterns as not serving their interests. They are seeking, instead, work practices that offer a balance between work and home (Wainer, 2004). Some male GPs also support the notion of changing hegemonic ideas about work patterns and applying them to practice (Wainer et al., 2001; Young et al., 2001). They support their female colleagues in this context which reflects Gramsci's (Gramsci, 1999) notion that alliances

between groups can build their strength in order to challenge so-called conventional wisdom. Such a process suggests that resistance to the social structure has the potential to transform dominant ideas about medical work and impact on practice.

In his extensive body of work, Bourdieu (2002: 19) discusses the notion of the individual as an agent for potential change rather than as a passive recipient of the ideas espoused by dominant groups. Somewhat similarly, in his structuration theory, Giddens (1986: 16) discusses the ‘dialectic of control’ where structures of domination in social systems do not automatically produce ‘docile bodies’. In other words, dominant structures or institutions can also be influenced by the activities of subordinated people who cease being **passive** individuals and become agents for change. Bourdieu (2002: 19) argues that agents think reflexively. When they become conscious and critical of the objective, structural reality, they are less likely to be motivated to internalise, or accept as the norm, those objective realities that do not serve their interests. Bourdieu sees the two, structure and agent, in a dialectical relationship:

... the objective structures ... setting aside the subjective representations of agents, form the basis for these representations and constitute the structural constraints that bear upon interactions; but, on the other hand, these representations must also be taken into consideration particularly if one wants to account for the daily struggles, individual and collective, which purport to transform or to preserve these structures (Bourdieu, 1989: 15).

Nonetheless, a hegemonic relationship implies that dominant groups may use their power to gain acceptance for their ideas from those in subordinate groups. More specifically, male rural GPs who work long hours may exert their authority to gain consensus for their work practices by subordinating those of female GPs who want to work fewer hours. The power and status accorded male GPs in their role as rural doctors and their position as providers for their families may also influence their spouses to subjugate their own professional or educational aspirations and assume the role of primary caregiver in the home. However, female spouses can also act as agents for change and resist structural constraints in the context of work practices by expressing and acting on their

own sense of entitlement to seek occupational fulfilment. Acting as agents, they have the potential to transform rather than reproduce hegemonic ideas and practices. In other words, they can support their own interests and contest hegemonic ideas, values and discourses.

Gender as a structuring principle in Western industrialised societies generally locates men as dominant and women as subordinate in social relations (Connell, 1987, 2002). Bourdieu (2002) suggests that men's dominance is taken for granted and many women accept their own subordination without realising that such patterns of gender relations are not natural but are socially constructed and reproduced to make the dominance of men in gender relations seem natural. Bourdieu (1977; 2002) introduces the notion of symbolic violence which plays an important role in his analysis of domination in general and is central to understanding how inequitable gender relations are reproduced. In this context, symbolic violence occurs when the dominance of men is legitimated as part of the normal social order whereby women are treated as inferior and denied resources (Bourdieu & Wacquant, 2002: 167). Jenkins (1993) sees Bourdieu's idea of symbolic violence as contributing to a theory of socialisation whereby various ways of thinking and acting are internalised by groups and classes in a way that masks underlying power relations. Kraus describes symbolic violence as:

... a subtle, euphemised, invisible mode of domination that prevents domination from being recognised as such and, therefore, as misrecognised domination, is socially recognised (Kraus, 1993: 172).

Connelly and Healey explain further by stating that symbolic violence:

... represents the way in which people play a role in their own subordination through the gradual internalisation and acceptance of those ideas that tend to subordinate them. It is an act of *violence* precisely because it leads to the constraint and subordination of individuals, but it is also *symbolic* in the sense that this is achieved indirectly and without overt and explicit acts of force or coercion (Connelly & Healey, 2004: 15, emphasis in original).

Internalising 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 2002: 167) implies that such actions

are perceived as a normal part of gender relations. According to Bourdieu, women's complicity occurs because they accept uncritically ideas constructed by the dominant group as the way things are and ought to be:

Of all the forms of 'hidden persuasion' the most implacable is the one exerted, quite simply, by the *order of things*' (Bourdieu & Wacquant, 2002: 168).

Bourdieu (2002: 73) introduced the notion of 'doxa', describing it as 'an uncontested acceptance of the daily lifeworld'. He uses the term to illustrate how dominated social groups, such as women, accept their subordination without realising they are being oppressed and without seeking to change the situation by challenging the so-called conventional wisdom (Webb, Schirato, & Danaher, 2002). In other words, Bourdieu suggests that women's 'doxic acceptance' of their subordination does not occur because they feel coerced or manipulated. It occurs because they accept as axiomatic men's dominance even though they may be treated unfairly and restricted in their expectations or opportunities (Webb et al., 2002: 25). Bourdieu argues that many women accept men's dominance *because* they misrecognise the symbolic violence being perpetrated and instead experience it as something normal and natural within the existing social order. In doing so, they legitimate such dominance and prevailing gender practices are reproduced. According to Bourdieu:

... symbolic violence accomplishes itself through an act of cognition and of misrecognition that lies beyond - or beneath - the controls of consciousness and will' (Bourdieu & Wacquant, 2002: 172)

Bourdieu argues that symbolic violence typically involves 'misrecognition' whereby relations of power are often hidden and seen 'not for what they objectively are but in the form which renders them legitimate in the eyes of the beholder' (Bourdieu & Passeron, 1977: xiii). Actions that subordinate the needs of women constitute 'symbolic violence' when they hide power relations at a structural level that restrict women's choices at the level of social practice. Evidence of this is found in contexts where women accept less wages than men for doing the same amount of work, where women are employed full-time and also take primary responsibility for the demands of domestic duties and

childcare, or where women are restricted in furthering their occupational or educational aspirations. According to Kraus (1993) 'complicity' implies that if someone is confronted with an act of symbolic violence such as being treated as inferior, they may decode relevant signals and sense the violence at some level but not recognise it for what it is, a form of domination. While some women may be aware of acts of symbolic violence directed against them, they are often constrained to change the situation by the very structures that reproduce the 'order of things'. Other women may take for granted men's dominance in gender relations believing it to be normal behaviour or even that it supports the common good. Some women may not want to change prevailing gender relations because of the benefits they gain by conforming to conventional expectations. In effect, women may 'misrecognise', or choose to ignore, or feel powerless to change the power imbalance embedded in such relations that, while hidden, is inequitable and can be exploitative.

While Bourdieu's view of gender relations has been criticised as being overly deterministic (Butler, 1990, 1993; Jenkins, 1993), it nevertheless highlights the inequitable distribution of power. However, Bourdieu claims that the dominant group is not consciously duplicitous in reproducing inequitable gender relations (Lechte, 1996). Wacquant (Bourdieu & Wacquant, 2002: 168) suggests that Bourdieu's theory of symbolic violence differs from Gramsci's theory of hegemony in that dominant groups do not consciously seek to gain the consent of subordinate groups:

... the legitimation of the social world is not ... the product of a deliberate and purposive action of propaganda, or symbolic imposition; it results, rather, from the fact that agents apply to the objective structures of the social world structures of perception and appreciation which are issued out of these very structures and which tend to picture the world as evident (Bourdieu, 1989: 21).

Rather, the privileged position of the dominant group within the social order and within social institutions gives it a platform on which to gain the consent of subordinate groups into believing the conventional wisdom it has effectively constructed (Lechte, 1996). That this 'conventional wisdom' is accepted is evident in the beliefs and practices of both the dominant and dominated classes

or groups (Bourdieu & Wacquant, 2002). Ideas supporting the dominant position of men in gender relations have been legitimated as part of the social order and underpin the formation of a consensual reality. This suggests that actively seeking women's consent to such ideas is no longer necessary as many have accepted and internalised such ideas and practices as normal and natural.

While the notion of symbolic violence may help in understanding how inequitable power relations between groups are reproduced, it fails to explain women's complicity adequately. A more nuanced interpretation puts forward the idea of the consequences for women if they do not comply with dominant expectations. Indeed, some women may accept that gender relations are inequitable but choose not to contest the 'daily lifeworld' for various reasons. They may choose to comply because of social pressure or because they feel powerless to change the situation or may not want to change the situation because of what they may stand to lose if they challenge the existing social order. They may also comply because of the enormous effort it would take to go against their social conditioning and challenge male dominance and privilege and because of the structural constraints they may encounter if they did challenge the social order. Women may not only accept their subordinate role to fit the so-called 'norm'; they may also choose that role because they are more likely to be valued and gain social acceptance if they conform to hegemonic practices where men are the main provider and women are the primary caregiver, even if women are in paid employment. Thus, men's position of dominance occurs because ideas supporting their position of power in the social order are also seen as normal and natural. Women who are married or in a committed relationship may also acquire social status, material wealth and financial security if they partner with someone from within the hegemonic group such as a doctor or a lawyer. Rhodes's (2001: 353) qualitative analysis of wives of professionals in the mining industry shows how a 'good wife' is one who subjugates her professional interests to become a 'consort, helpmate and moral supporter' where she can 'release her engineer from domestic duties, to free him from childcare and to withdraw her own occupational competition in order to promote instead his image through her social skills'. This choice assures her 'financial security and a comfortable lifestyle'.

If women demand changes to structural inequities present in current gender relations that reinforce their subordinate status in their relationship, they may risk losing the benefits of their position if the partnership or marriage ends (Tavris, 1992). This suggests that women's complicity to conform may also be shaped by their perceptions of the consequences if they resist. Indeed, the costs are more pervasive because of what women stand to lose socially and economically if they challenge the prevailing social order. According to West and Zimmerman (1987: 146) women are held to account when they resist hegemonic expectations by 'fail[ing] to do gender properly' rather than the structuring principles that underlie the inequitable distribution of power and reproduce the dominance of men in gender relations.

## **Resistance**

Connell (1977) argues that, when analysing hegemony, counter-hegemonic activity needs consideration. He claims that the relationship between dominance and subordination is never total. In other words, no group exercises total control over another group. Instead there are always 'circles of resistance' (p.207). Connell suggests that cultural forces of control within the hegemonic relationship can be contested, weakened and changed as part of a counter-hegemonic process (p.220). Ortner (1989: 200) argues that tension generated from the struggle in resisting dominant ideas and beliefs at the level of social practice paves the way for structural change. Yet she also suggests that if people do not see alternatives to prevailing hegemonic ideas and practices, or do not have the institutional power to implement the alternatives, dominant practices are reproduced. In a gendered context, power can be contested when male dominance is resisted. Ortner (1989: 196) suggests that the concept of power is present in hegemonic structures and 'practised ... lived ... enacted ... challenged, defended, renewed, changed'. Indeed, according to Williams, the practice of hegemony does not passively exist as a form of dominance but is constantly:

...renewed, recreated, defended and modified. It is also continually resisted, limited, altered, challenged by pressures not at all its own (Williams, 1994: 598).

Rural general practice is a site where change is occurring as hegemonic ideas about medical work practices are resisted and alternatives sought. Medical practitioners have historically been male and worked full-time. Their wives have often stayed at home and taken on the role of primary caregiver thereby making it easier for GPs to work long hours (Finch, 1983; Fowlkes, 1980). In this way, dominant ideas about gender roles and medical work practices have been reproduced. However, as growing numbers of women in medicine resist these dominant work patterns, their calls for counter-hegemonic work practices question Gramsci's (1999: 12) notion of an unconscious, 'spontaneous consent' to norms in social relations espoused by the dominant group because of its position of power and leadership within the social order. Many women are refusing to agree to work patterns that do not meet their needs. Such resistance also highlights Bourdieu's notion of proactive 'agent' where women may redefine their role to better serve their interests rather than passively complying with how it has been constituted to serve the interests of the dominant group.

It is at this point that I examine gender as social practice more specifically in the context of relationships of power in the social organisation of the family and medical practice.

### **Gender as social practice**

The notion of gender can be understood as a structuring principle that is played out in social practice. Connell (1987; 1995; 2002) draws on the idea of hegemony to examine the relationship between structure and social practice to help understand gender relations. He argues that the inequitable distribution of power is an important aspect of the structure of gender relations. This is evident in how roles are negotiated and experienced in the family in relation to the division of labour. However, Connell (1987: xiv) resists any attempt to clearly define gender roles that might belie their complexity or the 'sheer intractability of gender relations'. He does concede that, notwithstanding the multiple ways masculinity and femininity are depicted, there is an ordering principle, however circumscribed, governing gender relations in society that reinforces men's dominance over women.

Structural factors can be seen to reproduce gender relations that serve the dominant group's interests by encouraging and affirming individual and collective action that supports those interests at the level of practice. This position evokes beliefs, values and ideas that maintain male dominance within social institutions. In this way the concept of hegemony as a structuring principle shapes ideas, beliefs and values about what constitutes 'normal' social practice in subordinate groups in the context of gender relations.

Power in gender relations is institutionalised in the medical profession and the family. The work practices of female GPs are often subordinated to those of their male colleagues. In the home, female medical practitioners may support their spouse's role as provider and often take responsibility for the caregiving role in the family on top of their medical workload (Crompton & Le Feuvre, 2003; Lapeyre, 2003). The more diffuse nature of power in gender relations is evident in broader discourses on how women are represented. Often such discourses reflect a more intimate, pervasive illustration of hegemony that affects an individual's sense of identity and place within the social order (Connell, 2002: 36). A case in point is the dominant portrayal in the media of dominant ideas about the position of women in relation to men. Desirable women in many TV commercials are those who conform to such ideas by being beautiful, young and thin or, if they are mothers of young children or teenagers, attractive, competent caregivers in the home, even if they work full-time. Connell (2002: 59) suggests that a relationship exists between power operating through institutions such as the family and discursive power. He draws on Foucault's ideas who argued that power operates discursively where it is diffused through language, both speech and text. This form of power is more intimate. Both aspects of power inform or reflect each other and influence the social practice of gender.

People's expectations and experiences lived out on a daily basis serve as a 'site' for compliance with, or resistance to, hegemonic ideas, beliefs, and values embedded in social institutions or in contexts where power is more diffuse. The dialectical relationship between structure and social practice is revealed when such ideas and values are contested, opening the door to other possibilities of practice (Connell, 2002: 9-10). Tension within this relationship is present when female medical practitioners contest dominant ideas supporting an

heroic commitment to long working hours. Their choice to approach work practices differently challenges the conventional medical work ethic, causing discontinuity that undermines dominant beliefs but can lead to change. According to Pringle, women's resistance is not accompanied by any notion of revolutionising medical practice:

Women did not self-consciously or as a unified group set out to transform medicine but their presence is producing changes beyond what any but a tiny minority may have ever visualised (Pringle, 1998: 222).

Structural changes have occurred where conventional approaches to medical work practices are being reconsidered to meet more effectively the needs of growing numbers of women in the medical workforce, many of whom want to balance the competing demands of work and home (Pringle, 1998). However, compliance with hegemonic ideas is contextual and not necessarily transferable across settings. Consenting to dominant ideas in one setting may require resisting them in another. In order to meet dominant expectations of their role as caregiver in the home, women may opt for more flexible hours in the workplace. This theme will be examined later in the thesis.

The dialectical relationship between structure and social practice is also revealed in the tension and frustration many GPs feel in response to economic and political changes impacting on their work practices. The interests of the medical profession in maintaining control over its work practices intersect with government policy that fosters financial deregulation, competition for services and cost effectiveness. Health reforms requiring increased accountability from the medical profession may undermine doctors' autonomy and control over their work practices. Resistance from medical practitioners to such 'guidance' may cause tension that can lead to changes in structural patterns. However, tension can also emerge when medical practitioners consider they have little choice but to conform to such structural requirements. In this case, the work practices of medical practitioners change in light of structural constraints.

### **Political and economic changes and rural general practice**

Critical medical anthropologists Baer (1986) and Singer (1990; Singer & Baer, 1995) also argue that wider structural elements affect social practice. They

suggest that State support of a medico-centric approach to providing health care is linked to hegemonic beliefs and patterns outside medicine. These include political and economic factors where interests serving dominant groups underpin power relations. State support for neoliberalist principles may conflict with the interests of the medical profession at the level of practice, reflecting the hegemonic position of the State in shaping medical practices, a theme discussed later. Yet, State support for neoliberalist ideas intersects with a medico-centric approach to health service delivery reflecting, at another level, the alliance between the medical profession and the State. Examples of this alliance include government allocation of health resources that supports the construction of medical solutions to the rural health problem where the answer to better health care in rural communities is often seen as supplying more doctors (Abbot, 2004; Kamien, 1987; Keleher, 1999; Strasser et al., 1997), and the dominant position of the medical profession in relationships with other health professionals (Freidson, 1970; Germov, 2003a; Willis, 1989). Health care is often subsumed under medical care which, with its curative focus, gives less priority to other causes that may determine an individual's health such as socio-economic factors (Baer, 1982; Humphreys, 1985; Nord, Richardson, Street, Kuhse, & Singer, 1995).

Determining the interplay of power in relationships between the State, the medical profession and the consumer helps to explain how hegemonic ideas about health care 'inform interpersonal relationships, shape social behaviour, generate social meanings and condition collective experience', and come to be accepted as the norm within society (Singer, 1990: 181). In forming a consensus supporting a medico-centric approach to health care which is seen as common sense and part of conventional wisdom, groups or individuals may misrecognise relations of power and control that subordinate other approaches to health care. Indeed, resistance to dominant views on health care is constrained by 'hegemonic messages confirming the given-ness, indeed the naturalness of the existing social order' (Singer & Baer, 1995: 344).

Such a process reflects the dialectical relationship between structure and social practice by pointing to the diffuse and discursive nature of power in social relationships that is 'localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local, covert level through sets of

specific practices' (Turner, 1997: xi). However, such power may be resisted, with the result that structures or practices can change. Doctors have enjoyed a long period of prestige and autonomy where their expert knowledge, strong relationship with the State, and the dominant position medicine holds in the area of health, has withstood contest from other health occupations (Freidson, 1970; Willis, 1989). The 1970s and 1980s saw the medical profession at the height of its dominance and power in matters related to health (Alexander, 2000; McKinlay & Marceau, 2002). Politically, its authority as expert in health and its ability to direct health policy continues to be recognised and acted upon. Economically, its capacity to determine its fee for services rendered is accepted, and clinically, it persists in subordinating other health professions to its control (Elston, 1991). The medical profession has also exercised autonomy in clinical practice. Its organisational structure operates independently of its management structure in relation to health reform and, even though it advises management, it has not been held accountable for the implications of decisions regarding health expenditure (Alexander, 2000).

White (2002) suggests that, at the level of practice, medicine, power and knowledge have co-existed, manifesting as a form of hegemony where a medico-centric approach to health care is accepted as the norm. Historically, the medical profession's power to exercise authority over other health occupations and shape society's beliefs about managing health problems have had important implications for health policy (Palmer & Short, 2000; Willis, 1989). Any threats to its dominant status, such as challenges to its autonomy, calls for changes to its fee structure or moves to expand the roles of other health professionals, have often been fiercely defended by medical practitioners (Palmer & Short, 2000).

Yet while the medical profession still dominates the health division of labour 'economically, politically, socially and intellectually' (Willis, 1989: 2), the strength of its position is weakening in light of political and economic changes. The Commonwealth government is seeking competitive and cost effective practices in health service delivery and, together with health consumers, is calling for doctors to be more accountable and transparent in their clinical practice. Promoting evidence based medicine is one strategy to assess the effectiveness of medical interventions. However, such State intervention in

clinical practice has often caused tension and frustration amongst many rural GPs who feel their autonomy and control over their work practices are being undermined (Palmer & Short, 2000; Strasser et al., 1997; Wainer, 2002). Despite the tension and frustration rural GPs experience, many are changing their practices and conforming to structural requirements.

Having provided a theoretical backdrop in which to examine the dialectic between structure and social practice in the context of rural general practice, I now review research findings on gender relations and political and economic change. My aim, in light of this project, is to address factors affecting the actions, expectations and experiences of rural GPs and their spouses and their decision to remain in a rural location.

### **Situating the study**

This section of the chapter extends theoretical ideas discussed earlier in specific contexts. First, it draws on studies to examine the impact of structural changes on social practice in the context of gender relations in the rural medical workplace and in the home. Second, it explores the effects of a changing political and economic climate on the autonomy and control the medical profession has historically exercised over its work practices. These perspectives offer a broader analysis within which to consider the future supply of a rural medical workforce.

### ***Feminisation of medical profession***

The institutional structure of many professions has been organised to reflect a gendered division of labour predicated on the male in the workplace as provider and the woman at home caring for the family (Fowlkes, 1980; Rhodes, 2001; Wise et al., 1996). While this division is changing in the workplace generally, with organisations in Australia introducing family friendly provisions such as flexible hours for childcare, few fathers are taking this up (Bittman et al., 2004). In rural general practice, hegemonic beliefs underpin the high ideals of the 'medical sublime' espousing medicine as a vocation involving a commitment to work '24 hours a day, seven days a week' (Pringle, 1998: 2). The social organisation of medicine, like other professions, originally evolved to suit men in conventional family constellations with the male as provider working outside the

home and the female remaining at home to take on domestic and childcare responsibilities (Hochschild, 1989).

However, more women than men are currently entering the medical profession in Australia (Wainer, 2003). Many choose to work flexible hours effectively challenging the 'medical sublime' and evoking resistance from within the medical profession (Pringle, 1998: 10). While some in the medical profession welcome the growing numbers of women, others resent their intrusion. They see women doctors as a 'subaltern' force, not 'real doctors' because they do not conform to the demands of an heroic work ethic and therefore cannot be seen as 'serious about their career' (Pringle, 1998: 181).

Few female medical practitioners over the years have felt that the medical profession's organisational structure has met their needs (Game & Pringle, 1983; Witz, 1992). Moreover, women have worked hard to accommodate hegemonic work practices while attempting to balance the demands placed on their time by their commitments in the home (Crompton & Le Feuvre, 2003). Working long hours has been difficult for female GPs given that many are also the main caregivers in the home. Findings from the *National Rural General Practice Study* (NRGPS) revealed that models of work practice involving inflexible, long hours were unappealing to female GPs who preferred a less rigid approach to the issue (Strasser et al., 1997). According to Pringle (1998: 3), this is not to suggest that women doctors should be placed in a position of 'marginality or victimhood'. Instead, Pringle argues that the sheer force of their growing numbers in medicine, their presence and speech, *are* destabilising the organisational structure of medicine. Nonetheless, as agents, female GPs also have the potential to transform work practices by not internalising constructed realities that do not serve their interests.

However, while women GPs may not be victims to their circumstances, hegemonic beliefs do constrain their practices. Female rural GPs are working in a profession whose skills, education and occupational position in the social order are highly valued and endowed with much status and prestige, reflecting its dominance. Within the profession itself, the negative responses of some male GPs to their female colleagues working part-time to meet their family

responsibilities (see Clearihan, 1999), suggest that status and prestige within the profession is contingent on conforming to hegemonic, male work practices to ensure they are reproduced. Female doctors who do not accept this work ethic are often treated with disdain by their male colleagues. Effectively, they are subordinated to their male colleagues because their work practices are not constitutive of being 'real doctors' (Pringle, 1998: 10). Such a response implies a form of symbolic violence given the negative effects on female GPs of work practices that only seem to value full-time commitment even though many female GPs are attempting to balance their dual roles between home and work.

However, as Connell (2002) and others argue, the dominance of one group over another is never total. The institutions that create that dominance also create the conditions for resistance. In a gendered context, power is contested when male dominance is resisted and, as a result, often weakened, a process that can occur institutionally and discursively. Many female GPs are resisting models of work practice that conflict with their own approach to practising medicine by working within a framework that supports an holistic approach and allows more flexibility in working hours (Kilmartin, Newell, & Line, 2002; Lippert & Tolhurst, 2001; White & Fergusson, 2001).

Yet female doctors' resistance to working long hours is often predicated on their wish to fulfil the demands of their role as main caregiver in the home suggesting that resistance to hegemonic beliefs is contextual. Indeed, structural constraints on the social practice of gender are problematic when transferred across contexts. This seems particularly relevant when few female rural GPs with families can meet the expectations of a male model of rural general practice when the conventional wisdom regarding the gendered division of labour in the home allocates the main responsibility for childcare and domestic tasks to women. If they become full-time rural GPs, do they forego having children, reverse roles with their partners or negotiate gender practices? In this context, to what extent are male spouses willing to re-structure their work practices to allow negotiation of responsibility for childcare and domestic tasks in order to combine the professional and career aspirations of both members of the couple in a way that is experienced as fair?

More male than female rural GPs are married or in committed relationships (Strasser et al., 1997). Most rural female spouses are the primary caregivers and are often supported financially by their GP partners (Nichols, 1997; Wise et al., 1996). Limited research is available on the expectations and experiences of male spouses of rural GPs. Nichols (1997) and Wise et al. (1996) suggest that in relationships where the female works as a rural GP, male spouses often conformed to expectations of their role as provider, generally working full-time in their original profession (Nichols, 1997; Wise et al., 1996). Research on female GPs in Britain and France shows that they conform to conventional social expectations and make choices during their training which assume they will take responsibility for the family and the home, which they frequently do (Crompton & Le Feuvre, 2003).

### ***Gender relations in the home***

Women who accept their role as primary caregiver as ‘normal’, even if it means relinquishing their own professional or educational aspirations, are reproducing hegemonic beliefs about gender relations. Female spouses of medical practitioners often feel they take second place ‘in relationship to both the status and the time demands of their husband’s work’ (Fowlkes, 1980: 82. See also Wise et al., 1996). In a rural medical context, many marriages or long-term partnerships have adopted conventional gender roles in the division of labour. The structure and organisation of men’s work often constrains the choices of women, particularly if they are financially dependent on their spouses and are expected to fit in with the demands not only of their husband’s occupation but also his leisure activities (Dempsey, 1990, 1992; Finch, 1983; Rhodes, 2001).

While this works well when women are prepared to accept the major domestic responsibility and provide support and respect for their husband’s demanding career, it does not necessarily generate happy marriages. Many of these marriages, whilst enduring, have not always been fulfilling (Gabbard, Menninger, & Coyne, 1987; Hall Yandoli, 1989; Nelson, 1978; Sakinofsky, 1980). Indeed, women may misrecognise that inequity in the division of labour, limited opportunities to meet educational or occupational aspirations outside the home can constitute a form of symbolic violence. Indeed, even when women also

provide economically for the family, beliefs and values reinforcing their supportive, caring position in relation to men's dominant role as provider may be strong. In response, many women may choose to comply with conventional gender role expectations even if it means they also work the 'domestic shift', often with limited assistance from their male partners. This has not been without cost. The more pervasive emotional effects of socially constructed gender roles are seen in an unpublished study of 107 doctors' wives in the United States. Harding (cited in Miles, Krell, & Tsung-Yi, 1975: 483) found that 77 per cent reported unhappy marriages with 92 per cent indicating their emotional needs were not met by their husbands. Research on suicide in England and Wales revealed five times as many doctors' wives as architects' or accountants' wives, committed suicide (Sakinofsky, 1980). A study of twenty doctors' wives in Canada showed that eighteen were unhappy, depressed and angry enough in their marital relationships to have had suicidal thoughts (Miles et al., 1975). In the United States, a survey on sources of conflict in marriage showed that 68 per cent of physicians and 65 per cent of spouses in the sample had either sought or considered marital counselling (Gabbard et al., 1987).

Although these studies are not recent, they offer evidence that hegemonic expectations of gender roles which are internalised as common sense or part of the 'normal' social order can have negative consequences. Women can misrecognise the symbolic violence being perpetrated even if it damages their health. Yet women's reluctance to seriously question inequities in gender relations helps to sustain and reproduce such patterns. A fundamental inequity in an organisational structure that prioritises the needs of men while disadvantaging those of women is evident in the medical profession and in some medical marriages. In order to adopt the role of primary caregiver, female GPs may choose to work part-time, and female spouses of rural GPs may choose not to work at all. They may subjugate their own aspirations for fulfilment outside the home and take responsibility for childcare and domestic tasks in order to support their male partner in his role as provider.

Feminists have attempted to show how women are subordinated and exploited in the gendered division of labour at home and in the workplace (see Bernard, 1982; Hochschild, 1989; Oakley, 1985). Marxists might assume that

exploitation can lead to resistance and revolution (MacKinnon, 1997), yet more recent research has shown that many women refute the claim they are being exploited. Instead, they view their husband's treatment as just and their own contribution to childcare and domestic tasks as fair (Dempsey, 1992, 1997a; Hakim, 1995, 2003b). Indeed, many wives of professionals, rather than seeing themselves as 'helpless victims of patriarchy, masculine oppression or marital inequality' (Rhodes, 2001: 352), embrace their supportive, caregiving role where their 'subservience is reinforced culturally and ideologically endorsing [their] withdrawal from the search for personal fulfilment beyond the home' (Rhodes, 2001: 353). Wives of professionals reflect their 'doxic' or uncontested acceptance of the social order as something normal and natural and misrecognise the symbolic violence present in the inequitable distribution of power in gender relations that subordinates their needs and aspirations. As long as the marriage or relationship is maintained and/or women reap the benefits of their conformity to hegemonic expectations such as social acceptance, financial security and social status the effects of women's subordination remain hidden. If the relationship breaks down, such effects are revealed as the standard of living, social status and career prospects of women drop while those of their husbands often rise significantly (Delphy, 1992).

Gender relations are set against a backdrop of social change where other structural elements are also impacting on social practice. Shifts in the political and economic climate are affecting the work practices of rural GPs often causing tension and frustration. Perceptions of the nature of health and illness, health policy and resource allocation and the role of the State in health care are changing (Singer & Baer, 1995: 60) with corresponding changes to medical work practices.

### ***Effects of political and economic change on medical work practices***

Changes in the political and economic climate are occurring in many Western industrialised countries including Australia because of the shift away from the principles of social welfare and towards those of neoliberalism (Rodger, 2000). Since the mid 1980s reforms to health care systems emerged as a major concern notwithstanding their differences in cultural, political, social and historical contexts (Chernichovsky, 1995). In most industrialised countries, the

welfare state as a means for redistribution and social protection has been wound back and superseded by a neoliberalist agenda (Rodger, 2000). A neoliberalist, or economic rationalist, position holds that the market is not only the best allocator of resources in an economy, but is seen as the 'only legitimate allocator of goods and services in society at large – not just the economy' (Battin, 1991: 296). Neoliberalists advocate reducing the size and power of the government and the public sector (Melleuish, 1997: 203) and promoting the notion of competition between organisations in the marketplace (Peck & Tickell, 1994). Cost efficiency and competition are seen to be more effective when individuals, not bureaucracies, are free to decide their own needs and set their own goals and priorities (Melleuish, 1997). This, according to Peck and Tickell (1994: 318), has led to an 'explicit rejection of both the social partnership and traditional forms of welfare-ism'.

In Australia, neoliberalist policies have supported this type of economic restructuring and reform which has constituted a significant move away from the post-war welfare policies (Beeson & Firth, 1998; Hindess, 1998; Rees, 1994). As a result of this shift, health care has become a commodity to be bought and sold. Individuals' rights and responsibilities to make their own decisions about health care and the efficiency of allocation of health services take precedence over government, social and economic regulation (Duff, 2001: 31). Gone are the days of Australians viewing health care from an egalitarian perspective as a social good free from economic values (Latham, 1994) where health care was seen as a right rather than a privilege (Humphreys, 1985). In the current climate, governments have reduced services and shifted some of the burden of meeting health and welfare needs to private markets (Duff, 2001).

This change raises an interesting conundrum in the context of hegemonic relationships. Pre-existing alliances between the State and the medical profession that have reproduced hegemonic ideas and practices are being challenged by a powerful third party, the market. The coalition between the State and the market that supports neoliberalist principles informing resource allocation for health funding rests less on the State's loyalty to its alliance with the medical profession and more on policies promoting competition and cost effectiveness. Such a potential threat to the strength of the State/medical profession alliance reveals a

tension between these dominant structures. At the end of the day, the medical profession's struggle to maintain its strong alliance with the State is being undermined by the State's infatuation with market forces. Even though the medical profession's most 'strategic and treasured' possession is its autonomy, it is the State that has ultimate autonomy' (Freidson, 1970: 23) when it comes to the organisation of health services.

Some studies argue that the medical profession is weathering the storm without any noticeable dents to its power base. Freidson (1994 cited in Germov, 2003a: 301) suggests that it has responded to structural changes without succumbing to major threats to its power. While the autonomy of individual doctors is increasingly constrained by bureaucratic and corporate requirements as well as by informed consumers questioning their expertise, Freidson argues that the collective autonomy of the medicine as a profession remains intact. However, Kuhlmann (2002) suggests that expert knowledge and practices in health care systems are being re-negotiated in a climate where professional boundaries are becoming more porous. Collaboration, teamwork and flexibility amongst professionals are favoured over the hegemony of the autonomous solo practitioner reflecting the need to research the professions in a context of social and cultural change to better understand those influences. While such changes are not heralding the end of professionalism, Kuhlmann argues that the role of the medical profession in a knowledge based and service oriented society needs to be redefined.

Other studies reflect on how social changes have affected the values and work practices of the medical profession. They argue that the autonomy of the medical profession in its work practices is increasingly being called to account. The dominant position medical practitioners hold in health care delivery is considered by some to be less secure as the profession goes through a period of struggle in many Western nations. The tendrils of neoliberalist principles underpinning market forces are being felt in medical work practice. Increased pressure by government to rein in health care costs, technological advances in medicine, increasingly articulate, informed consumers, the rise in litigation against doctors (Calnan & Williams, 1995; Eve & Hodgkin, 1997) and the increasing numbers of women entering the medical workforce are reinforcing

these changes. Patients, whilst becoming more demanding of their doctors, have also become less respectful and more critical (Sibbald & Young, 2001). Such developments suggest a shift in the position of patients from being passive individuals who accept the dominant position of the medical profession uncritically to becoming active agents who question practices they consider may not serve their own interests.

As a result of these overall changes, some researchers argue that the power and status embedded in the hegemonic position held by the medical profession are starting to waver (Hafferty & Light, 1995; McKinlay & Arches, 1985). The 'golden age of doctoring' (McKinlay & Marceau, 2002: 379) is declining due to structural factors including the changing nature of the State and the loss of its partisan support for the medical profession, particularly in the light of neoliberalist principles. White (2000a: 286) goes further to explain that the impact of structural requirements is weakening the power base of GPs. He claims that the current political and economic climate requires that medical practice succumb to fiscal control through cost containment and accountability in clinical practice. He suggests that this demand commodifies medical services and effectively threatens the medical profession's autonomy and control over matters related to health thereby undermining its hegemonic position. Added to this, GPs are experiencing increased surveillance of their practices by their funding sources as a result of more widespread use of technology. This concerns the profession as it sees itself caught between the State and the market. Moreover, increasing corporatisation in the medical field, such as investment corporations buying up general practices for profit, further decreases the autonomy of medical practitioners as they are required to work under the terms and conditions specified by the organisations that employ them (Duff, Larsen, Tonts, & Ainsworth, 2000; White, 2000a). Competition from other health professions to provide services previously offered only by the medical profession and a shift in focus towards medicine being seen within a business context is further diminishing its status within the community (Pearson, 1993; Sutherland & Cooper, 1992; White, 2000b).

However, not all researchers agree that the hegemonic status of the medical profession in health care delivery is diminishing. Elston's (1991: 83)

work from Britain on the politics of professional power, argues that the medical profession is making 'uncomfortable adjustments' to socio-economic change rather than such change threatening the institutionalised patterns supporting its hegemonic status in the area of health service provision. Nevertheless, Sutherland and Cooper (1992) suggest that these structural changes are leaving medical practitioners ill prepared for the challenges to their autonomy and position at top of the health hierarchy. Indeed, the dialectical relationship between structure and social practice is evident as doctors 'worldwide' are becoming 'dispirited, ... disillusioned, disinterested and despairing due to the havoc wrought by constant change and uncertainty' (Van der Weyden, 2001: 62). This sentiment was reflected in findings from the NRGP study with many doctors expressing their anger and frustration at increased government intervention in their work that required changes to their clinical practices (Strasser et al., 1997).

### ***Resistance to medical hegemony in rural health care***

Current attempts to broaden the debate on what constitutes rural health care beyond a medico centric approach have met with resistance from within the medical profession. Recent responses in the media by the medical profession to nurse practitioners taking up more responsibility have openly stated that nurses would be offering second class care to that offered by doctors. The Australian Medical Association (AMA) reiterates the dominant position of doctors in health service delivery and does not accept that nurses or nurse practitioners can replace the services they offer (Australian Medical Association, 1994). This is despite evidence suggesting that some of the work of medical practitioners can effectively be carried out by nurse practitioners with no significant difference in health outcome and quality of service (Richards, Carley, Jenkins-Clarke, & Richards, 2000). Indeed, the difficulty attracting GPs to fill positions in rural centres has opened the door to considering alternatives to health care provision. The increasing clinical autonomy and expertise of nurse practitioners, who are registered nurses working in an advanced clinical role, has led to them being able to practise independently under strict guidelines, notwithstanding stipulations from the medical profession that they work only in areas of need where a doctor cannot be found (Wicks, 2002). Registered nurses and Aboriginal health workers

also offer a restricted range of health care services in some rural centres which, in a city, would be provided by general practitioners (Strong et al., 1998).

While this practice is not new, the difference is in the voice of other health professions wanting changes to the medical dominance of health service delivery. These changes would include a greater acceptance of role flexibility and multi-skilling between medical and health professionals in the provision of health services in rural areas (Pearson, 1993). According to the Western Australian state government report *The Country Health Services Review* (Department of Health, 2003: 34) an 'excellent example of adaptive workforce strategy' to the problem of recruiting and retaining rural GPs would be to employ nurse practitioners. These health professionals would 'help to retain a good range of local health care for small rural communities that are unable to attract and retain a resident GP'. Such trends are reflected in medical workforce planning initiatives. These include new models of care where tasks are allocated to other health professionals thereby changing the market for medical services. However, a strategic approach to a skills-mix is yet to emerge (Duckett, 2004; Joyce, McNeil, & Stoelwinder, 2004).

Notwithstanding the increasing influence of market forces and shifting trends in medical workforce planning, the hegemonic alliance between medicine and the State persists at this point in the context of rural health service delivery where the consensual understanding of optimum health care privileges the role of medical practitioners. The dominance of a medico-centric approach is still reflected at a policy level where non-medical strategies, such as allocating resources to help rural communities create and promote health by strengthening the necessary infrastructure, are side-lined (Keleher, 1999). The medical profession has reproduced hegemonic beliefs by generally resisting any expansion of the discourse on health care beyond a biomedical approach to one that includes a broader vision for the health and social future for rural Australia (Keleher, 1999). Some health professionals argue that this response to rural health care implicitly undermines the role and value of the non-medical, rural health workforce and thwarts any idea of a level playing field between health and medical professions competing to provide services in the spirit of neoliberalist principles. According to one Australian rural pharmacist:

There needs to be a very clear and unashamed commitment to the non-medical workforce...At present almost all the emphasis has been on medicine...money [has been spent] and programs established for GPs and their families...the rest of the health professions being very poor cousins by comparison. The politicians need to look beyond medicine and they have to put some serious money into nursing, pharmacy and other health professions. It's a great model but there is more to the health workforce than doctors (National Rural Health Alliance, 2004: 10).

These comments raise another question about whether better health is contingent on appointing more doctors or adopting a broader approach to the health issue. Keleher (1999) argues that, to improve the population's health, the medical profession has long promoted the idea that more doctors are needed in rural locations. Yet in 1996, almost double the number of medical practitioners provided services in metropolitan centres compared to some small, isolated rural areas (Strong et al., 1998). In 2000, estimates of the shortfall of GPs in rural areas in Australia ranged between 750 – 2000 leaving rural areas with fewer GPs despite initiatives to encourage GPs to practise outside capital cities. The ratio of 144 medical practitioners per 100 000 people in rural Western Australia falls far short of the average 260 per 100 000 for the Australian population as a whole (Australian Institute of Health and Welfare, 2000). According to Boffa (2002: 303) over-servicing the wealthiest in Australia is unacceptable while the poorest and those with the worst health status, often Aboriginal Australians in isolated rural areas, have great difficulty accessing GPs to meet their needs.

Suggestions to help correct this imbalance have been framed within the biomedical paradigm. They have included providing more students places in medical schools and increasing the number of overseas trained doctors working in Australia (Australian Medical Workforce Advisory Committee, 2004b; Australian Rural and Remote Workforce Agencies Group, 2004). A more controversial suggestion has been to change the distribution of Medicare provider numbers which are currently allocated to doctors who have fulfilled the requirements for registration with state medical boards. This solution arose because most GPs choose to practise in cities, a choice that leaves many rural areas under-serviced or without a GP. Ideas for reform include restricting provider numbers to an equitable, agreed-upon ratio of the distribution of GPs to

population. In areas of high morbidity, this ratio would need to be higher than the national average based on need (Boffa, 2002). Alternatively, provider numbers could be re-allocated based on geographic areas of unmet need (Hamilton, 2001). According to Boffa (2002) AMA resistance to these proposals is a major reason preventing more equitable access to GPs for some Australians. As a result, many private practitioners continue to operate in locations where the profits are highest, rather than on the basis of greatest need for their services. Until governments are willing to regulate their choice of location more equitably to ensure effective coverage in all areas, the situation of inadequate and inequitable allocation of medical resources is likely to continue (Humphreys, 1985). Attracting GPs to live and work in rural areas has been made more difficult by the negative effects of political and economic change on rural restructuring and development that have done little to make these areas more appealing to GPs and their families.

### ***Rural restructuring and development***

Neoliberalist principles informing changes to public policy are underscored by the belief that the extension of free markets will benefit everyone and lead to welfare reduction. However, according to Gray and Lawrance (2001), such ideas are social constructions that serve the vested interests of the powerful, not least global corporations who determine the future of rural Australia. Those living in rural areas have little access to such corridors of power and instead rural society in Australia is 'saddled with limited reflective capacity and interminable powerlessness in its relationship with metropolitan Australia' (Gray & Lawrence, 2001: 182) reducing its options and perpetuating rural/metropolitan inequities.

Restructuring rural communities in Australia, where demographics and infrastructure have been reconfigured, is set against a backdrop of neoliberalist principles underpinning political and economic decision making (Battin, 1991; Hindess, 1998; Rees, 1994). Market forces are given more freedom as deregulation and privatisation replace government subsidies and intervention (McKenzie, 2003). Images of the rural idyll where the Australian bush is synonymous with intimate, rustic communities have been replaced by pictures of crisis and conflict over the contentious effects of such policies on those living

and working in rural locations (Lockie, 2000). Social and economic decline in rural areas has been precipitated by reduced commodity prices, metro-centred social and economic policies, out-migration of local populations, and changing ownership patterns of rural economic enterprises (Cocklin & Alston, 2003).

Australia's rural research programme also prioritises economic efficiency over social needs in rural communities (Black et al., 2000), with insufficient attention being paid to the inequitable impacts of rural restructuring in government policy (Fagan & Webber, 1995). Policies focusing on cost cutting and competition have led to essential services being withdrawn, threatening the identity and viability of many towns in rural Australia (Tonts, 2000). This significantly affects the wellbeing of the local populations (Black et al., 2000; Tonts, 2000) particularly given that the availability of services is a significant contributing factor to community sustainability (Cocklin & Alston, 2003: 2). Many public services have either been reconfigured to be more cost effective or sold to the private sector (Black et al., 2000) where their resources are consolidated in larger rural centres. This change has had a significant impact on smaller rural centres due to difficulties accessing those resources because of distance. As central government reduces subsidisation schemes, local government and agencies in large rural centres have picked up the tab for attracting industries to local areas (McKenzie, 2003).

These structural changes have left many rural locations in Australia struggling to attract and retain GPs in an environment where health care provision is woefully inadequate compared to services offered in metropolitan centres (Australian Institute of Health and Welfare, 2002). The drive for capital accumulation, cost effectiveness and profit conflicts with the health needs of the general population (Baer, 1982; Humphreys, 1985). The new paradigm in healthcare reform in Western industrialised countries has been implemented to develop a satisfactory private/public mix to promote equal access to a basic health care package (Chernichovsky, 1995). However, the notion of equal access to a basic health package in rural Australia is questionable when compared to services offered to those living in metropolitan areas. Cost cutting has led to reduced access to health and welfare services particularly more isolated rural

areas where economies of scale make viable commercial operations difficult (Duff et al., 2000).

The effects of the shift away from social welfare policies are reflected in a substantial body of evidence pointing to poorer morbidity and mortality rates among those living in rural locations. Such evidence justifies the need for a reassessment of what constitutes 'equitable' health care and how to appropriately meet that need (see Australian Institute of Health and Welfare, 2002). The health industry is now seen as an institution governed by economic logic rather than social welfare where 'self-interested action' is seen as a 'better guarantor of social progress than any traditional norms and values' (Davis, 1993: 121). Indeed, reforms related to health care and rural development and restructuring have reduced access to health care and other services in some instances. They have also further burdened rural communities with the emergence of a 'moral' framework where the individual rather than society is expected to take more responsibility for their health and welfare needs (Latham, 1994; Rodger, 2000). In a social climate where the gap between rich and poor is purportedly widening, the effects of dominant ideas about health care based on economic logic rather than social welfare are seen in the health status of rural residents compared to their metropolitan counterparts, seriously questioning the notion of a common good. It is against this political and economic backdrop that GPs are being recruited to work in rural locations.

### ***Effects of social change on rural medical service provision***

In Australia, the picture painted of GPs' experience of rural general practice shows their professional autonomy, independence and their ability to practise a variety of medical and procedural skills (Lawrance, 2001), opportunities often not available to urban GPs. This image of rural general practice, whilst realistic in part, has been affected by political and economic changes. Such changes have added to the sense of uncertainty and frustration many rural GPs feel. Many smaller country hospitals have been downgraded in the services they offer, resulting in limited opportunities for GPs to practise their procedural skills, regardless of their qualifications and experience.

Negative aspects of political and economic changes were also reported in findings from a qualitative analysis of the *National Rural General Practice Study* (Wainer, 2002). Many rural GPs resented the financial stress and loss of professional autonomy resulting from shifts in government policy. They were angry at being caught in a profit squeeze between static incomes and rising costs and at any threat of a federal government freeze on Medicare rebates. Such action would adversely affect their incomes particularly in light of rising costs in practice management and medical insurance. Concern about threats of medical litigation affected how they practised medicine, including their relationship with their patients, and reduced their enjoyment of work.

Rural GPs were also angry and frustrated that increasing bureaucratic surveillance and government intervention in clinical practice were eroding their professional autonomy. Many GPs abhorred the bureaucratic intrusion into their work practice and there was an ‘underlying simmering resentment at the controls being imposed on doctors and the requirement to conform to imperatives other than clinical judgement’ (Wainer, 2002: 20). Economic downturn in rural environments reflected in many services being withdrawn, contributed a pervasive sense of negativity about rural general practice leaving many GPs feeling frustrated and exhausted (Wainer, 2002).

Locating the recruitment and retention problem within a broader structural context reveals that GPs may not consider that the impact of political and economic changes on clinical practice serves their interests; instead it often leads GPs to feel tense and frustrated. At another level, structural constraints intersect with the autonomy and control of the medical profession. This is evident in the current drive for cost effectiveness that may conflict with the power of the medical profession to determine its own work practices. In this light, competition from other health professionals to provide services once only offered by doctors is legitimated by health policies supporting neoliberalist principles. Indeed, other health professionals are providing services in areas unable to attract GPs, thereby opening the door to considering alternatives to a medic-centric solution to the problem. While the medical profession may no longer be considered ‘the sole repository of legitimate medical knowledge’ (White, 2000a: 286), the issue of recruiting and retaining rural GPs becomes a

‘site’ where hegemonic views about rural health care are being contested. Many rural GPs are struggling to come to terms with the effects of these changes that are causing tension in rural GPs’ relationship with the State.

Tension is also evident between the medical profession and other health professions where registered nurses have filled the gap as total health care practitioners ‘when it has not been possible to retain the services of medical practitioners’ (Pearson, 1993: 215). While some argue that nurses want to take over the doctor’s role by becoming surrogate GPs, others suggest that nurses are being exploited when assumptions are made that they will carry out that role in the absence of medical practitioner (Hegney & McCarthy, 2002). Renegotiating roles in a context of diverse rural health services can benefit the overall needs of the public. According to Keyzer (1997: 187), advanced nursing practice involves a higher level of clinical decision making and integrates ‘practice, education research and management into [advanced nurse practitioners’] daily work’. It is the ‘old order’ of the health care system that needs to be open to change whereby the skills of other health professionals can be successfully employed as part of the goal of improving standards of rural health:

Rural doctors have more to fear from holding onto past practices and outdated attitudes than they have from developments in nursing practice. This is a time for collaboration between rural nurses and doctors to promote healthy rural communities (Keyzer, 1997: 188).

Indeed, preserving a medico-centric approach to rural health can be problematic for several reasons. It can deflect from addressing the complexity of issues underlying rural health that relate to broader structural determinants such as political and economic factors. The effects of such factors impact on rural communities and can affect the success of recruiting professionals. They, like local community residents, face challenges such as limited infrastructure, inadequate services, fewer opportunities for professional development, a less diverse culture and lifestyle and diminishing populations because of out migration (McKenzie, 2003; Tonts, 2000), that may make working as GP in a rural location less attractive. Rather than tackling some of the broader issues underlying recruitment and retention by adequately resourcing improvements to

areas such as infrastructure and services in rural locations, governments take a different route. They focus on making rural general practice more attractive by offering generous financial incentives to GPs and their families that are not available to most other professionals or workers. Such a response reproduces the inequity between health professions reflected in the privileged position and status the medical profession holds in the health system and within the community. Hegemonic ideas regarding rural health care are reproduced in the belief that '[m]ore than ever in rural communities, what patients want is a local doctor' (Humphreys & Rolley, 1998: 940).

The notion that rural areas are deficient in what they provide for GPs and their families is reflected in governments offering financial incentives to attract GPs to work in rural locations, as if to compensate for what is lacking. While rural restructuring and development have had negative effects on some rural areas, the choice to compensate doctors does not examine whether it is the expectations of GPs and their spouses that are unrealistic in how they view life and work in rural locations. It presumes, instead, to improve conditions in their immediate environment to better meet those expectations such as offering a high standard of housing often at no cost to the GP but at considerable expense to the community with no guarantee that the doctor will stay (Mills, 1997). Doctors are provided with generous incentives to work in rural locations, incentives that are not often offered to others, suggesting that the relationship between the medical profession and the State, while undergoing changes, remains strong. Health policies in Australia continue to reproduce the dominance of a medico-centric approach to rural health care many of which are designed to induce doctors to practise in rural areas (Australian Government Department of Health and Ageing, 2004; Palmer & Short, 2000). Less emphasis is placed on examining a broader approach that would acknowledge diversity between rural areas and assist communities to improve the infrastructure that can promote health, as well as making rural towns more attractive places in which to live and work for all professionals and workers. The diversity of health needs between rural communities, and innovative approaches to health care provision have been subsumed under a 'one-size-fits-all' approach.

This raises the question of how the concept of 'rural' is represented. Differences between communities and regions are often ignored in research on rural health care needs. Health care needs become essentialised and subsumed under the banner of homogeneity. Diversity, whether in geographic location, class, age, ethnicity, race, educational status and employment opportunities, is effectively ignored (Chesters, Han, Strasser, & Ballis, 2001). Restructuring and redevelopment of rural locations has magnified diversity between rural locations: inland areas may be suffering economic decline, withdrawal of services and out-migration of young adults at the same time that attractive coastal areas are booming (McKenzie, 2003). One recent study on attracting and retaining professionals in non-metropolitan areas in Queensland found that solutions that worked in one area were not always transferable to another (Miles, Marshall, Rolfe, & Noonan, 2004). Acknowledging differences opens the door to finding innovative and appropriate solutions to meeting the rural health problem.

Evidence suggests that a national approach to recruitment and retention of professionals is needed that acknowledges diversity between rural centres and rural communities. This would involve collaboration between local, state and federal government authorities as well as professional groups, universities and development and community groups in large rural centres to develop a more customised approach to meet the diversity of needs. The participation of communities in this process heralds the importance of integrated attempts to find solutions to this complex issue (Miles et al., 2004).

In the meantime, despite governments and local communities offering Australian trained rural GPs generous incentives to live and work in areas of need, GPs are reluctant to leave the cities and vacancies for rural GP positions persist. An alternative solution has been to recruit overseas trained doctors to fill the vacancies unwanted by their Australian trained colleagues. Sourcing doctors from overseas is not without its problems. Geographic, cultural, social and professional isolation contribute to difficulties facing overseas trained doctors and their families in settling into a new community. These may be exacerbated for GPs and their families from culturally and linguistically diverse backgrounds living and working in rural areas, some of whom have had to contend with local and institutionalised racism (Miles et al., 2004). Recent media coverage of

OTDs has often been negative. Media reports covered a high profile case of the alleged involvement of an inadequately trained and inadequately supervised overseas trained surgeon from overseas in the death of several patients in Queensland.<sup>6</sup> This case highlighted several issues including the need to monitor screening procedures, opportunities for professional supervision and social support for their effectiveness in protecting the public and the OTD and his/her family. Recruiting OTDs from poorer developing countries also raises ethical questions regarding their own medical workforce being depleted if they leave, threatening the viability of ongoing health programs in their countries of origin (Scott, Whelan, Dewdney, & Zwi, 2004). While beyond the scope of this project, ongoing debate is needed to adequately address the complexity of these issues.

The next section examines how well rural GPs generally are coping with the effects of structural changes at the level of practice.

### ***Rural GPs' responses to structural change***

Kamien's (1998) ten year follow-up study involving 90 per cent of the original 101 participants in the 1986 *Ministerial Inquiry into the Recruitment and Retention of Country Doctors in Western Australia* found that 63 per cent of GPs were still practising in rural Western Australia. Reasons given by those who left rural general practice included personal issues, such as their children's education, their spouse wanting to leave and feeling exhausted themselves. Rural GPs feeling worn out and frustrated were also key findings in the analysis of qualitative data from the 1997 NRGP study. The difference in the NRGP study was GPs' anger and frustration at recent changes in government policy that decreased their professional standing and autonomy over their work practices (Wainer, 2002). While rural GPs may be making 'uncomfortable adjustments' to structural changes, some are ill prepared for challenges to their power and autonomy, as discussed earlier. In terms of recruiting more doctors, Birrell (2001) postulates that the only serious incentive for GPs to relocate to rural areas is difficulties they face in establishing a viable metropolitan practice.

---

<sup>6</sup> See article in *The Age* newspaper on 11 June 2005 by Mark Todd and Tom Noble: 'Dr Death to be pursued for murder'; also, Cath Hart and Sean Parnell's article: 'Global police hunt for Dr Death clues' in *The Australian*, 20 July 2005.

Yet is this the full picture? While findings from the NRGp study showed the negative effects of structural change on work practice (Strasser et al., 1997), they also showed that the anticipated length of time GPs stayed in a rural practice is close to 20 years. My own research indicates that major structural changes in the last 30 years have indeed created tension amongst rural GPs as many struggle to come to terms with the implication of such changes on their work practices. However, this has led some rural GPs to become increasingly reflexive about their role and work practices seeing the changes as inevitable and working with them where they experience the benefits rather than the disadvantages. It has also led some to reassess the notion of balance between work and home. This process suggests a dialectical relationship between some rural GPs and the State whereby GPs' tension and frustration as they struggle to come to terms with constraints have also led to changes in ways they approach medical work practices. Other rural GPs are less optimistic with some being openly resentful of structural requirements. Nevertheless, the majority of GPs whom I interviewed were planning to stay working in a rural area with one commenting that rural general practice was 'the best kept secret'. Overall, despite 'uncomfortable adjustments' to social changes, GPs in this study were far more positive about rural general practice than other studies suggest, pointing specifically to its advantages rather than its disadvantages. This is significant in the light of recent approaches to recruitment and retention of rural GPs, a subject discussed in the next chapter.

## **CHAPTER 2**

### **Recruiting and retaining GPs and their spouses/families in rural locations**

In a survey of nearly 5000 medical practitioners in post-graduate vocational training, rural general practice was not a popular choice. It was seen as a high risk area of work made more unattractive by threats of being sued by patients and of rises in medical indemnity insurance (Australian Medical Workforce Advisory Committee, 2003: 10). Vocational training provides GPs with appropriate levels of supervised experience to 'assure the community that they have the essential knowledge and skills to practise competently' (Australian Government Department of Health and Ageing, 2005: 604). The above findings from the Australian Medical Workforce Advisory Committee are set alongside a pervasive image of rural health as one of decline and depression where providing more doctors is a cure (Keleher, 1999). Studies from the United States, Canada, Britain and New Zealand demonstrate that they, too, experience under-servicing of rural areas where an excess of medical practitioners work in the city (Easton, 1997; McAvoy, 2000-2001; O'Reilly, 1997; Rabinowitz, Diamond, Hojat, & Hazelwood, 1999). In Australia, medical services in many rural areas remain inadequate with governments unable to compel doctors to work in areas of need. The 1946 amendment of the Australian Constitution prohibits any form of civil conscription of medical practitioners following a successful High Court challenge in the term of the Chifley Labor Government which led to the amendment of section 51, paragraph xxiiiA.<sup>1</sup> One way Australian governments have chosen to resolve the problem is to maintain a medico-centric focus to rural health care and increase resources and incentives to support GPs and their families in the hope, not only of improving prospects for their recruitment, but also keeping them in rural locations once they arrive (Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002;

---

<sup>1</sup> See <http://www.aph.gov.au/senate/general/constitution/par5cha1.htm>

Fleming, McRae, & Tegen, 2001; MacIsaac, Snowden, Thompson, Crossland, & Veitch, 2000; Veitch, Harte, Hays, Pashen, & Clark, 1999).

Findings from other studies on medical recruitment and retention in Australia often indicate that the problem of attracting doctors lies in the rural environment. Many rural GPs consider their living conditions, the demands placed on them by the rural community and the hours they are expected to work as unacceptable (Kamien, 1987; Strasser et al., 1997; Wainer, 2002). Government responses have focused resolving such difficulties in the hope of making rural GPs' lives easier by allocating millions of dollars in incentives in order to attract GPs and their families to rural locations and to encourage them to stay (Australian Government Budget, 2003; Australian Government Department of Health and Ageing, 2003, 2004). Solutions have included providing good quality housing, offering better opportunities for spouses and ensuring adequate time off for relaxation. Notwithstanding such inducements, predictions persist of even greater shortages of GPs in rural areas (Access Economics, 2002).

As a result, a deeper enquiry into the problem is necessary. The current focus on meeting the needs of rural GPs and their families reinforces the notion that responses to rural health care must include resolving problems in the relationship between the GP and the rural environment. More broadly, this focus reinforces the idea that the problem of rural health care requires a medico-centric solution and is often defined by recruitment and retention issues. Community acceptance of this approach as the norm reflects not only the hegemonic status of the medical profession in rural health care delivery but also the strength of its alliance with the State in successfully promoting its ideas, values and beliefs about rural health care. In this light, local communities may offer generous incentives to attract and keep GPs in the area (see Mills, 1997).

However, maintaining a medico-centric focus can deflect from examining the broader determinants of health in a rural setting such as poverty and unemployment that can impact significantly on health outcomes. This is not to suggest that rural GPs consider unimportant a social model of health care that directs attention to a wider range of health determinants; neither does it imply that rural GPs consider unimportant the role of prevention of ill health through other factors such as community participation and social reforms (Germov,

2003b). The issue under consideration centres more on the fact that rural GPs work within a model that is concerned mainly with the diagnosis and treatment of illness, or the malfunction of the body's biological systems, within a biomedical framework (Germov, 2003a). This perspective leads many rural medical practitioners to feel 'overwhelmed with the urgent' where non-emergency issues, such as population approaches to health and community education, are 'put on the back burner once the next trauma arrives' (Worley, 2004: 1). Given the effects of socio-economic changes on the delivery of medical services, the question raised is whether a biomedical approach is the most appropriate response for attaining good health care outcomes in rural communities.

### **The social practice of rural health care**

Keleher (1999) argues that improving health in a rural community is less about providing medical solutions to treat illness and more about improving health in the context of social development. She suggests that governments should allocate resources to strategies that assist communities to improve the infrastructure that can create and promote health. For this to occur, a shift in political will is needed that would allow for the development and implementation of more broadly based, permanent solutions to the problem. There are concerns that prioritising economic over social criteria will lead to the lack of sustainability of rural communities (Black et al., 2000; Haslam McKenzie, 2000; Tonts, 2000). Many young men and women are leaving town and the populations of inland rural centres in the wheat and sheep belt in Western Australia are decreasing (Tonts, 2000) despite population growth in many coastal areas (Smailes, 1995). This scenario illustrates the diversity between rural communities that governments need to examine when considering issues of equity as well as efficiency in rural health service delivery (Black et al., 2000).

One solution to the rural health problem is to increase the use of nurse practitioners. According to the AMA this is permissible only where doctors are unwilling to practise, often in the most inhospitable and isolated locations (Australian Medical Association, 1994; Pearson, 1993; Siegloff, 1995). However, there is evidence that nurses are being 'forced by circumstances' (Siegloff, 1995: 116) to provide medical services in rural areas despite the lack of

legal defence for nursing actions beyond the scope of nursing practice (Hegney & McCarthy, 2002). Further debate is necessary on this issue in light of social changes already impacting on the delivery of rural health services. New models of health care are being developed, funding and licensing arrangements are changing and more health professionals are competing with the medical practitioners to provide health services. Currently, some non-medical health professionals are eligible for private insurance and Medicare rebates (Joyce et al., 2004).

However, attempts to extend the rural health care debate beyond a medico-centric approach have met with resistance from the AMA which claims that medical services are a 'matter of life and death in rural and regional areas and must be supplied 24 hours a day, 365 days a year' (Australian Medical Association, 2001a: 4). The power of this position underpins a cultural logic within Australian society that assumes the need for a local doctor in rural locations. However, notwithstanding the difficulty attracting rural GPs, the priority given to a medico-centric approach is sometimes problematic in light of social changes that are opening the door to other ways to respond to the rural health issue.

Nonetheless, governments continue to provide generous incentives to GPs and their families in the hope that they will want to live and work in rural locations. However, trying to persuade Australian trained GPs and their families to leave the city is no easy task. Many are reluctant to adapt to life and work in rural towns which are often seen to lack the attractions of a middle-class, urban lifestyle (Kamien, 1987). Studies have often remained focused on the negative effects for GPs of working in these locations such as professional and social isolation, long working hours, limited peer support and reduced access to amenities such as choice in education for children (see Strasser et al., 1997; Wainer, 2002). The negative effects of current rural restructuring and development are also all too real in towns now struggling to remain socially and economically viable (Haslam McKenzie, 2000).

Structural changes are also affecting medical work practices which may well exacerbate the problem of providing rural GP services in future. The increasing feminisation of the medical workforce has seen the proportion of

women training for general practice in Australia rise to over 60 per cent (RACGP cited in Wainer, 2004: 49). In March 2003, male GPs comprised 70.3 per cent of the rural GP workforce in Australia and female GPs 29.7 per cent (Australian Medical Workforce Advisory Committee, 2005: 241). To consider working in rural areas, many want flexibility in their working hours, jobs for their spouses and good schooling for their children (Wainer, 2004).

Overall trends indicate that, while the number of rural GPs has increased in most states over the last 15 years, there has been a drop in full-time workload equivalents (FWEs) in all states except Queensland, Western Australia and the Northern Territory (Hirsch & Fredericks, 2001). Differences in numbers of GPs to patients ranged per 100 000 population from 122.7 GPs in capital cities, 111.4 in large rural centres to 66.1 in small, isolated rural centres (Australian Medical Workforce Advisory Committee, 2000: 35). In smaller rural centres, fewer female GPs provided services and more GPs worked longer hours including more on-call (Australian Medical Workforce Advisory Committee, 2000: 9). The shortfall in GP numbers in rural areas is creating problems in meeting the demand for services.

Added to this, the male rural medical workforce is ageing. The mean age of male GPs in Australia is currently 51 years and female GPs 44 years (Australian Government Department of Health and Ageing, 2005: 120). From 1984 to 2000, the proportion of GPs over 50 years rose from 28 per cent to 36.9 per cent (Hirsch & Fredericks, 2001). The isolation and distances between locations are factors constraining the recruitment of GPs in Western Australia (Donovan, 2003). Given younger doctors' reluctance to leave the cities, such factors raise questions about the availability of a future rural medical workforce pool to cover the demands of rural general practice. Nonetheless, governments continue to allocate millions of dollars to recruit GPs to work in rural locations in the hope that they will stay.

## **Recruitment of rural GPs**

### ***Incentives for Australian trained doctors***

In the prevailing discourse on rural health, the terms recruitment and retention have often been used interchangeably, sometimes generating ambiguity

in their meaning. Retention is often linked with recruitment implying that it automatically follows recruitment which may not be the case (Cutchin, 1997; Humphreys et al., 2001). Differentiating between the two terms will avoid confusion. Recruitment aims to increase the number of doctors in general practice, often using various initiatives to attract them. Retention refers to a minimum length of stay in a particular rural location although the meaning of 'minimum' is debateable and depends on who is defining it (Humphreys et al., 2001). Incentives to encourage retention are less developed particularly in the area of flexible working patterns (Leese & Young, 1999). This is significant given the increasing numbers of women entering the medical workforce wanting part-time hours.

It is readily acknowledged by the Commonwealth government that GPs are the 'foundation' of primary care in Australia (Abbot, 2004: 33) within the current system of health service delivery. The hegemonic status accorded the medical profession over other health workers has been evident in financial resources provided to various programs established by the government to assist in recruiting and retaining their services in rural locations. In the 2000-2002 budget, the Commonwealth government committed \$562 million over four years for a *Regional Health Strategy: More Doctors Better Services*, an extensive package of initiatives designed to provide more doctors and to improve health services in rural areas (Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002: 3). Given continued shortages of rural GPs the government re-funded the program in the 2004 budget to the tune of \$830 million over the next four years (see Abbot, 2004). An extensive bureaucratic infrastructure was established to implement strategies to recruit and retain rural GPs.

The Australian Rural and Remote Workforce Agencies Group (ARRWAG) was established as a national, non-government organisation funded by the Commonwealth Department of Health and Ageing. It was set up in 2000 with agencies located in each State and Territory in Australia. Its objective was to develop and promote the recruitment and retention of GPs to rural areas in the respective state or territory the agency was located. It aimed to do this by improving the capacity of the general practice workforce to meet the health care

needs of rural communities (Australian Rural and Remote Workforce Agencies Group, 2003-2004). Rural Workforce Agencies (RWAs) administer funds at a local level to deal with shortages of GPs and develop strategies to improve access to GP services. They also administer various grants to rural GPs on behalf of the Commonwealth government in the hope of retaining their services. These grants include financial support for relocation, locum assistance, continuing medical education, and initiatives to support rural GPs and their families. RWAs also deliver education to rural practitioners, help rural communities to recruit GPs and organise locums to allow GPs to attend professional development courses (Lyle, 2002).

The Rural Retention Program (RRP)<sup>2</sup> for GPs is another program that aims to encourage GPs to stay in rural general practice. The program provides financial rewards to recognise long-standing rural GPs who have provided services. Information on this group of GPs is gathered from either Medicare data or other sources. Rural Clinical Schools have also been established as part of the University Departments of Rural Health<sup>3</sup>. They provide experience in country practice and training in rural settings by offering clinical placements for medical as well as health science students, hoping to encourage their relocation to rural areas. Medical students can also be offered rural, bonded scholarships of up to \$20 000 tax free annually, to study for their degree. In return, students agree to work in a rural location for six years once they have graduated (Birrell, 2001; Boffa, 2002; Wearne & Wakerman, 2004). At this stage, it is too early to evaluate the success of this initiative.

The Practice Incentive Program (PIP) is a \$241million program established in 1998 which aims to recognise general practices that are either accredited to the RACGP standard for general practices or are working towards accreditation to improve quality care for their patients. Incentives are generally paid to the general practice and target specific areas such as information management, information technology, after hours care, teaching, and employing practice nurses. The PIP program encourages quality of patient care rather than

---

<sup>2</sup> See <http://www.ruralhealth.gov.au/workers/rrp.htm>

<sup>3</sup> See <http://www.ruralhealth.gov.au/studying/index.htm>

the quantity of patients seen by the GP by compensating GPs who carry out long consultations or do after-hours work (Australian Government Department of Health and Ageing, 2005: 78-80).<sup>4</sup> For those practices involved in the program, other financial incentives flow on. The 2001-2002 *Federal Budget Nursing in General Practice Initiative* allocated a further \$104.3 million over four years to encourage general practices in areas of high workforce pressure to employ more nurses.<sup>5</sup>

The Divisions of General Practice Program<sup>6</sup> was established in urban and rural locations throughout Australia and was funded by the Commonwealth government (see map 1). Divisions of general practice were set up in 1992 to forge better links between GPs and other health agencies. Australian Divisions of General Practice (ADGP) are a key partner with the AMA, RACGP and RDAA (Australian Government Department of Health and Ageing, 2005). Their aim is to improve patient health outcomes by encouraging cooperation between GPs and other health professionals and offering opportunities and support for them to meet and work together. Divisions of general practice also offer services where they represent GPs in the hospital and community. In these contexts, they negotiate GP access to hospitals, provide continuing medical education for GPs, organise peer review and quality assurance in patient care, facilitate undergraduate teaching and vocational training, and participate in primary care

---

<sup>4</sup> For further information, see:

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-pipepcreview.htm>

<sup>5</sup> See <http://www.health.gov.au/pcd/programs/nursing/budget.htm>

<sup>6</sup> See <http://www.ruralhealth.gov.au/workers/dgp.htm>

This item has been removed for copyright reasons.

**Map 1: Australian Divisions of General Practice.**

Source: Australian Government Department of Health and Ageing, 2005, *General Practice in Australia, 2004*, p.613

research, health promotion and education (NHS 1992 cited in General Practice Strategic Policy Development Unit, 2000: 11).

It is against this backdrop of government support that Australian trained doctors have been actively recruited to work in rural locations. Such generous incentives are not offered to other health professionals, notwithstanding their significant role in rural health care. The ongoing difficulty in attracting Australian trained medical practitioners is met by providing more incentives for them to work in areas of unmet need. If doctors agree to work in these areas, they are now eligible to apply for relocation grants that can amount to \$20 000 for a single GP and \$30 000 for a married GP couple (Western Australian Centre for Remote and Rural Medicine, 2003).

Yet with such lures, why are Australian trained doctors so reluctant to leave the cities and work in rural areas of unmet need? One response to this question is seen in the decline of rural populations raising questions of viability in establishing a private general practice. Consequently, many communities are recruiting salaried or overseas trained doctors (Jones, Humphreys, & Adena,

2004). According to the findings of the *National Rural General Practice Study* GPs are increasingly unlikely to want to work under conditions traditionally associated with general practice in rural locations such as long working hours, unacceptable on-call arrangements and lack of locum relief (Strasser et al., 1997). These findings suggest that expectations for rural GPs to have an heroic commitment to meet the demands of their work are changing. Nonetheless, GPs seem reluctant to move outside the city with its lifestyle, choices in education for their children within a reasonable distance from home, acceptable on-call arrangements, job opportunities for spouses, professional training, housing, and cultural activities (Holub & Williams, 1996; Kamien, 1987). Boffa (2002) suggests that GPs prefer to work in more desirable urban locations with better working conditions and income protection, even though their choice often creates a surplus of GPs relative to the needs of the community (Boffa, 2002: 301). According to Kamien (1987: 41) this decision would make sense given that most doctors are drawn 'mainly from middle or upper middle class ... [where] it would be expected that, when in the country, many would miss the trappings of middle class society'. Add to this the limited number of medical graduates brought up in rural areas and an overall picture emerges of the distribution of GPs between urban and rural locations.

As a result, further incentives are offered to encourage GPs to move to rural areas. The Australian General Practice Training Program (formerly the RACGP Training Program) offers a three year training course with two pathways, rural and general. It consists of a hospital year, a six month basic term followed by a six months advanced term and a year of experience as a GP. Registrars can then choose a further year in advanced rural skills training. Those who opt for the rural pathway are offered financial incentives by the RACGP if they agree to do 18 months of their training in rural locations. Places on the Australian General Practice Training Program (formerly the RACGP Training Program) have been increased from 400 in 1997 to 600 in 2004. Competition for entry onto the program is fierce, yet, despite the inducements, many rural registrars return to urban general practice when they have completed their training (Australian Government Department of Health and Ageing, 2005)

Studies often imply that GPs view rural practice ambivalently in that the factors that lead them to work in a rural location also inform their decision to leave. In other words, GPs may be attracted by the diversity of work practice that rural general practice offers, including the opportunity to provide continuity of care to the community. Many GPs also enjoy a sense of independence and autonomy working in this setting (Strasser et al., 1997). However, the flip side of the coin is often overwork, unacceptable after-hours on-call arrangements, inadequate locum relief, professional isolation, limited access to continuing medical education in some areas and the inability to do procedural work when hospitals downsize or close. Add to this a lack of childcare facilities, few opportunities for spousal employment and subsequent deskilling of spouses, family pressures, and relationship breakdown (Kamien, 1987; Maher, 2001; Strasser et al., 1997; Wainer, 2002) and the picture painted is less appealing. Recognising the challenges faced by rural GPs and their families is important. Isolation and distance from family and friends and professional support can make settling in difficult (Humphreys & Rolley, 1998; Kamien, 1987, 1998; MacIsaac et al., 2000; Snadden, 1993). However this is the case for many workers and professionals leaving their families and friends to set up a new life in rural Australia, though most have to survive without the generous resources, incentives and support offered to the medical profession and their families.

In contrast to a gloomy depiction of life outside the cities, there are those who grew up in rural Australia, love the rural lifestyle and want to return. Students with rural backgrounds are four times more likely to work in rural medicine than those who grew up in the metropolitan area (Kamien, 1987: 74). In the United States, the most important predictor of a doctor choosing rural practice was having a rural background (Rabinowitz et al., 1999). Despite this finding, there are GPs and their spouses who have always lived in the city but who choose to live and work in a rural location. They embrace the rural lifestyle, including opportunities to farm. They enjoy the autonomy and skills rural practice offers in terms of clinical independence and procedural work (MacIsaac et al., 2000). Many rural GPs and their families are happy to be part of the local community and often develop a loyalty to those living in the area, a factor that contributes significantly to their decision to stay (Green, 1993; Hays, Wynd,

Veitch, & Crossland, 2003; Lippert & Tolhurst, 2001). These responses were certainly evident in my own research which will be discussed in later chapters.

While difficulties persist in attracting Australian GPs to work in rural locations, particularly in locations designated as areas of unmet need, solutions continue to be sought within a medico-centric paradigm. The Commonwealth Department of Health and Ageing (DHA) and the Department of Health in Western Australia determine districts of workforce shortage within the RRMA classification (See Table 1). Vacancies in these locations are initially advertised to Australian trained GPs. If positions remain unfilled, OTDs are increasingly being called upon to bridge the gap in medical services in these areas (Birrell & Hawthorne, 2004; Donovan, 2003). While this solution offers a stop-gap in medical service provision, it can be problematic. In isolated smaller rural locations, professional or cultural support for incoming OTDs is often limited. Miles et al. (2004) argue that these issues need to be resolved if recruitment and retention is to be successful. Many of the locations in which rural OTDs initially work are designated as areas in need of medical services that are often located inland and may be isolated. This picture reflects the diversity of rural general practice and the challenges posed by some settings, important issues when considering the adjustment to a new way of life not just for OTDs but also their spouses and families, particularly those from different cultural and linguistic backgrounds.

Since 2000, the Commonwealth government has committed millions of dollars to meet the needs of rural medical practitioners which has included encouraging the Divisions of General Practice to support OTDs working in special workforce programs (Australian Government Department of Health and Ageing, 2003). According to Birrell and Hawthorne (2004), OTDs will be recruited over the next few years as the mainstay of the Commonwealth government's Medicare Plus program to provide 1500 full-time equivalent (FTE) positions in areas of need. As a result, active recruitment of OTDs was, and still is, considered necessary to provide medical services in rural locations, at least until sufficient local graduates fill the places (Australian Medical Workforce Advisory Committee, 1999; Donovan, 2003).

However, increasing the number of local graduates to fill the places offers no guarantee that the situation will improve in areas of unmet need, given the reluctance of many Australian medical graduates to work outside cities. Indeed, concerted efforts to resolve the problem by allocating Medicare provider numbers based on areas of unmet need in order to provide a more equitable distribution of Australian trained medical graduates (Hamilton, 2001) have been thwarted by the medical profession. The AMA cites legal advice that refutes the geographical distribution of Medicare provider numbers. It claims this would coerce doctors to work in these areas which contravenes the “civil conscription” clause in the Australian Constitution (Australian Medical Association, 2001b). AMA resistance and State support of a medico-centric approach to rural health care suggest that employing OTDs to fill positions unwanted by Australian medical graduates will prevail for a while yet.

Claims of an over-supply of medical practitioners in Australia, supported by figures showing that the medical workforce had doubled from 1976-1996 even though the Australian population grew by only 30 per cent (Australian Medical Workforce Advisory Committee & Australian Institute of Health and Welfare, 1998), were resoundingly rejected by the AMA. The AMA argued that there was an undersupply of medical practitioners in urban as well as rural and outer-suburban Australia. Results from a survey commissioned by the AMA of 7000 GPs showed that part of the reason for this under-supply was inadequate remuneration and the need to train more GPs in the future to fill this gap (Phelps, 2002). This argument implies that, with the right financial incentives, GPs will want to work in areas of unmet need when evidence shows this is not the case. Yet any moves by governments towards a better distribution of the medical workforce have generally been met with resistance such that positions in rural areas remain unfilled. Any kind of diffusion of rural GP services with those of other health professionals to provide a more collaborative and innovative approach to rural health care has also been resisted by the AMA (Australian Medical Association, 1994).

However, in order to meet the health needs of rural communities, the Western Australian *Country Health Services Review* demonstrates the need for flexibility in rural health service delivery rather than reinforcing a medico-centric

focus. The report recognises rural diversity where a one size fits all approach is not always appropriate to meet rural health care needs (Department of Health, 2003: 22). Whilst the importance of the medical profession in rural health service delivery is recognised in the report, it is interesting to note that the future of sustainable, private, rural medical practice was seen as doubtful despite significant investments from local and Commonwealth governments in incentives to attract and retain doctors (p.25). Nevertheless, in response to GPs' demands for better conditions in rural locations (see Strasser et al., 1997), the Commonwealth government continues to support the need to offer more incentives to attract and encourage GPs to remain working in a rural area. Despite this, findings from a recent study indicate that there has been no change in the maldistribution of Australian trained medical practitioners with most rural communities relying on doctors trained overseas to provide medical services (KPMG Consulting cited in Boffa, 2002, p. 301). Unable to recruit locally trained doctors, incentives are then offered to attract and retain OTDs.

### ***Incentives for overseas trained doctors***

Fearing a political backlash from the growing crisis of inadequate medical services in rural areas, exacerbated by the difficulty in attracting and retaining Australian medical graduates, the Commonwealth government facilitated the recruitment of doctors trained overseas into hospitals in large rural centres and rural general practices. Visas granted to overseas trained medical practitioners increased from 875 in 1995-1996 to 1780 in 2000-2001 (Birrell, 2001). These doctors were recruited by state and local governments and private providers to work on short or medium-term contracts (Hawthorne & Birrell, 2002). The Commonwealth government had established pre-requisites for accreditation to practise medicine whereby OTDs entering Australia, except those from New Zealand, had to pass exams set by the Australian Medical Council (AMC). This required that doctors from non English speaking backgrounds complete an occupational English test in addition to passing the AMC medical knowledge multiple choice test and AMC clinical examinations (Birrell, 1997; Hawthorne & Birrell, 2002).

The Australian Medical Workforce Advisory Committee Working Party advocated the ongoing use of OTDs on temporary resident visas (TRVs), a

policy which looks set to continue indefinitely. It argued that this temporary medical workforce could fill essential gaps in services in those areas unable to attract Australian trained doctors (Australian Medical Workforce Advisory Committee, 1999). To meet the growing rural crisis, requirements to pass AMC exams were subsequently waived or removed by state medical boards. This move led to many OTDs on permanent resident visas (PRVs) feeling frustrated that they were being overlooked in favour of doctors on TRVs. To be eligible for a TRV, OTDs were required to work for up to four years in areas of need designated by the state or territory in which they were living. The AMC was not required to assess their medical qualifications (Birrell, 1997; Birrell & Hawthorne, 2004). Numbers of TRVs issued to OTDs increased from 664 in 1993-4 to 2496 in 2003-4 (Birrell & Hawthorne, 2004). OTDs on PRVs eventually were eligible for conditional registration if they agreed to practise in designated areas of unmet need where vacancies had not been filled by Australian trained doctors (Hawthorne & Birrell, 2002).

By the late 1990s, over 69 per cent of OTDs came from the United Kingdom and 10.3 per cent of doctors working in areas of unmet need were from South Africa (Australian Medical Workforce Advisory Committee, 1999). In 2001-2002, the majority of doctors who graduated overseas and who billed Medicare for their services had trained in Asia followed by the United Kingdom (Australian Government Department of Health and Ageing, 2005: 110). The recruitment of doctors trained overseas, who are on medium or short-term contracts in order to boost the numbers of GPs providing rural medical services, is still seen as an interim measure. Current policies aiming to increase the number of Australian graduates working in areas of need expect results by 2010. By then, it is assumed that the number of GP trainees will have increased and the number of doctors trained overseas will fall correspondingly. The present aim is to have a minimum intake of 450 medical practitioners onto the GP training program and to accept an annual intake of 200 doctors trained overseas (Australian Medical Workforce Advisory Committee, 2000).

### ***Western Australia***

The Overseas Trained Doctors' Program in Western Australia (WA) began in October 1999 and is currently administered by a Rural Workforce

Agency, the Western Australian Centre for Remote and Rural Medicine (WACRRM) in Perth. WACRRM is the only body eligible to admit doctors trained overseas onto the program in WA, which is the first of its kind in Australia (Donovan, 2003; Roach, 2003). This is a collaborative scheme requiring that OTDs work in a specified area of unmet need for five years under conditional registration with the state medical board. During this time doctors are required to pass an exam set by the Royal Australian College of General Practitioners. Once they have met these criteria, they are eligible to apply for an unrestricted Medicare provider number allowing them to practise anywhere in Australia (Department of Health, 2003; Donovan, 2003). These requirements have since been updated. A recent policy position statement by ARRWAG on OTDs recommends that in order to attract OTDs to work in very isolated areas, the Five Year OTD Scheme can be modified. Each year a doctor works in an isolated location counts for two years in a rural location. If an OTD remained in a isolated area for two and a half years, he/she would be eligible to meet the requirement of the five year scheme and be allocated an unrestricted Medicare provider number (Australian Rural and Remote Workforce Agencies Group, 2004).

On arrival in Western Australia, OTDs undergo a week long orientation program organised by WACRRM while they are completing medical registration procedures. In 2002, of the 68 OTDs entered onto the WACRRM data base who were working in rural Western Australia, 26 came from South Africa, 11 from the UK and nine from Nigeria (Roach, 2003). In the last two years, about 50 OTDs (10 per cent of the WA rural GP workforce) were practising under the Five Year Rural Recruitment Scheme (Department of Health, 2003). Before being accepted onto this scheme, OTDs are generally required to take up a locum position for six months where they can be assessed for their suitability for rural practice. This period also gives doctors and their families the opportunity to work out whether living and working in rural WA suits them. Sixty per cent of the locum work-force Australia-wide comprises OTDs on TRVs who have above average representation in Western Australia compared to other Australian states and territories (Donovan, 2003).

Incentives to attract OTDs to the program are varied. At a local government level, rural shire councils assist by often providing free or subsidised housing, a surgery and vehicle as well as ensuring doctors and their families are welcomed and supported by the local community (Department of Health, 2003). At a professional level, assistance with travel and orientation costs for the doctor, provision of workshops and examination and administration costs are also provided (Donovan, 2003).

### ***Maintaining medical care in rural locations***

Recruiting OTDs to work in designated areas of need that are unable to attract their Australian trained colleagues is one solution to the rural health problem. The belief that rural towns need a doctor has often been reinforced by health policy and accepted as the norm by rural communities. At another level, the diffuse nature of power in social relationships is evident when hegemonic notions of health care are reproduced in decisions made by local communities to resolve the rural health problem by providing and maintaining medical services (see Turner, 1997). Kamien (1987: 30) suggests that people living in rural locations have 'high expectations of medical services, often greater than is possible to provide'. On the other hand, it could also be argued that many doctors have high expectations of rural communities to provide for their needs. Much time, effort and financial resources have been allocated by rural shire councils to offer services to GPs such as finding locums, providing furnished housing and often a car, and navigating the maze of bureaucratic requirements in order to recruit OTDs. However, there is a sense of community frustration when, with that level of outlay and effort, doctors leave after a short period (Mills, 1997). This raises the question of how realistic are the expectations of both the local community and the GP about the process of providing services. In other words, how, and by whom and for how long should medical services be provided? Should a distinction be clearly drawn between health services and medical services?

Rather than expand the rural health discourse beyond a medico-centric focus, rural shire councils have generally worked within that paradigm. Some councils have contracted the services of private corporations who guarantee to provide the community with a GP and organise his/her recruitment for an annual

fee negotiated with the council. While the rural shire council often provides accommodation, a vehicle and a furnished surgery, the corporate organisation recruiting GPs may assist GPs to meet bureaucratic requirements, manage the practice and sometimes provide information technology (IT) equipment. The private GP will then pay a percentage of his/her income to the corporate organisation for practice management. The effects of this arrangement at the level of social practice will be addressed in subsequent chapters. While rural communities hope that such incentives will assure continuity of medical services, the question raised is whether such incentives contribute to the decision of GPs and their families to stay in rural locations?

## **Retention**

Retaining GPs and their families in rural locations is often portrayed as an either/or situation: either you stay or you leave (Cutchin, 1997). Cutchin (1997: 39) claims that many studies maintain a problem/solution focus and offer a list of factors that either lead to, or prevent, retention as if it were a 'nervous system response to a particular stimulation threshold'. This approach implies that the 'right' incentives will lead to the 'right' outcomes even though this has not been the case so far in terms of providing adequate rural GP services. Nonetheless, ARRWAG recently recommended even more financial incentives to attract doctors to work in rural areas over and above those they already receive (Australian Rural and Remote Workforce Agencies Group, 2003-2004). The linear approach of such studies does not address the complexities of the issue that are evident when seeking to understand 'retention' in a wider social context. Adopting a broad approach also allows a more nuanced exploration of the relationship between structure and social practice.

Maintaining the focus on attracting GPs to work in areas of need by increasing the financial incentives reproduces hegemonic ideas about rural health service delivery that effectively side-line creative solutions to the problem outside that paradigm. The experience and skills of other health professions are subordinated to those of the medical profession and a concerted effort to address other determinants of rural health in a way that may improve health outcomes and reflect diversity between rural communities are subjugated in favour of a 'one-size-fits-all' approach.

A medico-centric focus can, by definition, work against collaborating with other health professionals in a non-hierarchical setting. Instead it can and does create divisions between GPs and other health professionals and between GPs and the local community (Joyce et al., 2004; Keleher, 1999; Mills, 1997). Indeed, the financial and social costs incurred by many rural communities of recruiting GPs led one rural town to plead with new arrivals to 'become part of the community to be accepted and not just use it as a means of income' (Mills, 1997: 196). Interestingly, studies on retention show that GPs who are involved in the community are more likely to stay.

In Australia, Humphreys and Rolley (1998) stress the importance of GPs feeling part of the community. Kamien (1987) found that over 50 per cent of rural doctors in his study enjoyed their environment and were reported to be involved in the community. Hays et al. (2003) conducted a follow-up study on their original research where they re-interviewed a group of rural GPs after 10 years to discover why they were still in country practice. Of the 23 in the original cohort, 72 per cent continued in rural practice citing strong community links as one of the reasons they stayed. Over time, GPs' integration into the social fabric of the community made leaving a less attractive option. Those who were not integrated into the community tended to leave. In the United States, research shows that doctors who identify with, and feel part of, the community are more likely to develop a sense of loyalty to the location (Cutchin, 1997). Cutchin (1997) expands on this view by suggesting that new meanings emerge from those who have integrated into the community that suggest that place and community are reasons to remain in a particular location. Professional satisfaction is another reason.

Kamien (1987) discovered over 80 per cent of rural GPs in his early study found their work challenging and fulfilling. Over 90 per cent were satisfied with what they were doing and appreciated being able to use 'a wide range of skills and to provide a continuity of care to people they knew and whose family dynamics they often understood' (p.41). Kamien's (1998) later study examining the outcomes of GPs in his 1987 research, found that most participants were still concerned about overwork due to long hours with no locum relief, lack of medical back-up in emergencies, the downsizing of rural hospitals, insufficient

income and limited access to continuing medical education. Currently, GPs on average work up to 26 per cent longer in very isolated rural locations than those in major cities. Fourteen per cent of those in major cities work over 60 hours a week compared to 27-40 per cent in isolated rural areas (Phillips, 2005: 21). Despite this, of those who had planned to leave in Kamien's (1998) study, 49 per cent had stayed, and of those who had planned to stay, 24 per cent had left.

However, there seems to be a contradiction in factors affecting GPs' decisions: professional issues drive some doctors to leave at the same time as encouraging others to stay. This highlights the diversity inherent in GPs' expectations and experiences of rural general practice. Recent findings from a review of national and international published reports suggest that rural background is a significant factor in doctors remaining in rural practice (Laven & Wilkinson, 2003). However, a study from the US found that, while rural background was an important predictor in recruitment to rural practice, retention was more influenced by professional issues such as income and workload (Rabinowitz et al., 1999). GPs' responses to structural requirements suggest that increased bureaucratic intervention in professional life was another factor driving GPs to seriously consider leaving general practice altogether (Kamien, 1998). Findings from the NRGPs study found that many rural GPs were angry at the increasing government encroachment into clinical practice (Wainer, 2002). In Kamien's (1998) follow-up study to his 1987 research, over 50 per cent of GPs who had left rural practice had been unable to solve the problems they had and, understandably, felt despondent. However, those who stayed had resolved most of their concerns including overwork, forced deskilling and conflict with other health care professionals and they acknowledged the importance of their work in the community. This suggests a degree of ownership of responsibility to resolve the issue rather than projecting the problem onto others to solve.

Nevertheless, in order to encourage GPs to work in rural areas governments are attempting to resolve the problem by offering GPs a plethora of incentives to stay. However, it seems that many practitioners remain discontented in rural general practice with calls that not enough is being done to improve their plight. GPs continue to berate government for their demanding workloads, lack of locum relief and lack of access to services, not feeling valued and supported

for the work they do, and inadequate educational opportunities for their children (Strasser et al., 1997; Wainer, 2002). These concerns reveal the tension when GPs resist structural expectations by demanding changes to work practices. Notwithstanding a variety of incentives to make the life and workloads of GPs more manageable and enjoyable, heavy workloads persist and the physical and mental health of many GPs suffers. There is pervasive feeling of negativity about rural general practice underpinning the experiences of many rural GPs (Wainer, 2002). Stress, depression, relationship breakdown, alcoholism and high suicide rates amongst GPs relative to other professions are not uncommon and compromise quality in work performance (Winefield, 2003). Medical culture also acts as a constraining factor on doctors acknowledging and discussing their problems given the stigma attached to doctors seeking help (Frost, 2002). Not coping is seen as unacceptable and the doctor in the role of patient is considered an anomaly. As a result, doctors often minimise, deny and are reluctant to report any symptoms, conforming to the view that 'patients get ill, doctors don't' (McKevitt & Morgan, 1997: 648). Other research has questioned whether the stress of work is counterbalanced by their professional autonomy and the prestige and status they enjoy in the community where, despite morbidity, their job satisfaction is generally high (Winefield, 2003).

However, at the present time, many rural GPs are feeling their autonomy in their work setting is being eroded as rural general practice undergoes a transition in the light of structural changes leading to a sense of uncertainty and frustration surfacing among the rural medical workforce (Strasser et al., 1997). Added to this, Kamien's (1987) observation that rural centres may not meet the social and cultural needs of middle and upper-middle class GPs feeds into the notion that rural locations are deficient in meeting their needs as well as those of their families. Even though most rural GPs are married or in committed relationships, most studies on recruitment and retention centre on the needs of the GP with less focus being placed on the contribution and needs of their spouse.

Research into the spouse's role, expectations and experiences is limited. However, various studies have addressed the importance of meeting spouses' occupational, educational and training needs in rural areas (Nichols, 1997; Wise

et al., 1996) and the effects of their loss of identity as separate from that of 'doctor's wife' (sic) (Lippert, 1991). Kamien (1998) found the role played by spouses in the decision to stay or leave rural general practice was significant given that the 'the success and retention of a doctor depends to a large extent on the adaptability of the spouse' (Kamien, 1987: iv).

The image of the role of rural GPs' spouses, particularly the female spouses, is seen as supporting the work of their partners, often subjugating their own professional aspirations in the process (see Sevier, 1990; Wise et al., 1996). Repeated studies have overlooked the significance of gender analysis as a way to understand broader issues driving the recruitment and retention of rural GPs and their spouses. This thesis will pick up on changes to rural general practice brought about by gender relations. Not including spouses in the recruitment and retention process undermines their importance and reinforces their subordinate role. Chapter Eight directly addresses their expectations and experiences and the extent to which they are informed by structural issues. It examines the effect of hegemonic expectations of gender relations in social practice where perceptions of their role as 'doctor's spouse' are explored in relation to recruiting and retaining rural GPs. But first, I draw on the ethnographic tradition to contextualise the research by taking the reader on a journey through the region in the next chapter. I describe the locations in which GPs and their spouses live and work that provide a backdrop to their expectations and experiences and reveal the diversity of country general practice.

## **CHAPTER 3**

### **Country general practice: the place and the people**

The setting for this research is a richly diverse area covering 87,000 square kilometres in the southern part of Western Australia. This region is designated as the Great Southern Division of General Practice (GSDGP), represented as Area 609 on Map 2. The Division stretches from the coastal towns of Walpole in the southwest to Ravensthorpe in the southeast, north to Kondinin via Lake King and Lake Grace then west to Brookton (see Map 3). Towns are situated within specific rural shires within that circumference that are managed by discrete shire councils that constitute part of the organisational structure of local government (see Map 4). Towns covered by the GSDGP include the large rural centre of Albany, the service towns of Narrogin and Katanning, the vineyards and tourist centres of Mount Barker and Denmark, all medium rural centres with sufficient populations to support several GPs. The smaller, and often more isolated rural shires with populations generally well under 4000 offer the services of solo GPs. General practices are situated within specific shires where the surgery is located in the main town, often with branch clinics offered in smaller towns within the shire.

The landscape of the area covered by the GSDGP is diverse and ranges from the majestic beauty of eucalypt forests in the southwest, including the Valley of the Giants where tingle trees in the Walpole Nornalup National Park tower above the landscape, to Ravensthorpe in the east, close to the coast and currently the site for the proposed BHP Billiton \$950 million nickel mining operation. The flat, salt-lake plains dot the cleared, pastoral landscape of the more remote northeast of the region around Lake King and Lake Grace. This area stretches for hundreds of kilometres in each direction to be met in the south by sandy beaches extending along the coastline. The regional centre of the Great Southern area of Western Australia is Albany, an attractive, thriving coastal town of over 30 000 people. It offers numerous services for residents and tourists, well- maintained buildings that reflect its history as the first white settlement in

This item has been removed for copyright reasons.

**Map 2: Western Australian Divisions of General Practice**

Source: Retrieved January 2, 2005, from Western Australian Divisions of General Practice website: <http://www.gp.org.au/wa.html>

Western Australia, a natural deep water harbour and beaches with sand the colour of snow. The town has a genteel atmosphere, is home to many retirees and draws large numbers of tourists to the area not least because of its mild climate and natural beauty.

Descriptions of the various locations help to convey notions of diversity, distance and isolation that pervade the lives of those living and working in rural areas, particularly when accessing basic services such as health care, education and banking. I use my own observations and impressions to help the reader become acquainted with the land and its people as I visit and spend varying amounts of time in all the shires that offer the services of a GP. When meeting residents, I engage in informal discussions and explain the nature of my project and seek to understand their ideas and experiences of rural medical services. I

also make a point of contacting those who are more closely involved in implementing medical services such as individuals working in local government or state funded hospital and community health care. To substantiate my



**Map 3: The Great Southern region of Western Australia: Localities within the Great Southern Division of General Practice.**

Source: Retrieved January 10, 2005, from The Great Southern Division of General Practice website: <http://www.gsdgp.com.au/contact.aspx>

This item has been removed for copyright reasons.

**Map 4: Shires in Southwest and Great Southern Region of Western Australia**

Source: Retrieved January 3, 2005, from the Shire of Lake Grace website: <http://www.lakegrace.wa.gov.au/>

observations and impressions, and those of others, and to offer a more nuanced understanding of the landscape, history and socio-economic environment, I draw on archival material from libraries, local shire council offices, hospitals and tourist offices as well as census material from the Australian Bureau of Statistics. I also seek to understand the effects of socio-economic changes on rural restructuring and development and on medical service delivery by listening to local community responses. I visit government and other websites for added

information and resources relating to the various locations in the region and I make use of personal communication to clarify or elaborate on various issues.

## **Landscape**

I began my fieldwork journey by spending two months living in Albany which I used as a base to visit Denmark and Mount Barker, locations in reasonably close proximity. Albany is the administrative centre of the region covered by the GSDGP and is situated on the coast 405 kilometres southeast of Perth, adjacent to King George Sound. The English explorer and navigator, George Vancouver, named this expanse of water after King George III (Johnson, 1989). It is a natural, deep water harbour which was originally the main port in Western Australia before the construction and opening of the port at Fremantle, just south of Perth in 1897.<sup>1</sup> The mouth of the Sound faces eastward into the Southern Ocean towards the Great Australian Bight. Adjoining the Sound are two harbours, Oyster Harbour to the north into which flow the Kalgan and King Rivers and, to the west, Princess Royal Harbour flanked in the north by Point King and in the south by Point Possession, all areas of great natural beauty. Princess Royal Harbour is an expanse of water protected from the high seas and gale force winds. On the northern side of the harbour are Mount Melville and Mount Clarence. Albany rests on the slope between these two granite outcrops and the sea. Granite and limestone cliffs tower above white sandy beaches on the coastline around Albany and add to the ‘vistas of ocean and cliffs, harbours and hills and surf [that] make King George Sound one of the most beautiful and dramatic spots on the Australian coastline’ (Garden, 1977: 3). Southern right whales can be viewed from the shore as they migrate between July and September and sperm, humpback and the rare and endangered blue whales also swim through the waters off the southern Western Australian shores (Great Southern Development Commission, 2003). The Bibbulmun Track, named after Indigenous inhabitants of the area, is another feature of the region. It is a 900 kilometre walk from Perth through a variety of landscapes to Albany. It was

---

<sup>1</sup> Information obtained from: <http://www.freport.wa.gov.au/Educaton/history/1827.aspx>

officially opened in 1979 and was designed to encourage urban people to ‘go bush’.<sup>2</sup>

A holiday atmosphere prevails in Albany, even in winter, that helps to create a sense of vibrancy. People of all ages congregate in York Street, the main road in the town, as they attend to their business, stop to chat, shop, browse, take time out in one of the several, good coffee shops that reflect a burgeoning café culture in the town, or visit one of the pubs. I walk down the street flanked on either side by stately, federation buildings juxtaposed with modern retail outlets and, looking straight ahead, I can see King George Sound which provides a dramatic backdrop to the town. The hills around the city centre offer extensive coastal views for those fortunate enough to be able to afford to live there where an air of gentility prevails. Others can enjoy equally impressive views from driving or walking through Mount Melville or Mount Clarence.

The population of Albany is growing and has reached over 30 000. People are attracted to its mild climate, business opportunities, relaxed lifestyle, schools, health care services, attractive coastal scenery, bush walks, history and proximity to vineyards as well as the many organisations, clubs and sporting activities available for those wanting to be more actively involved in community life. There is a range of health and medical services including 31 GPs who work out of nine general practices. Numerous sporting and recreational facilities and an active arts community point to a rural centre that is thriving rather than declining. Tourists can choose from a range of holiday accommodation from the more luxurious hotels and self-catering boutique chalets to bed and breakfast accommodation and self-contained units to caravan parks and backpacker hostels.

Fifty one kilometres west of Albany and 400 kilometres south of Perth is the town of Denmark, which, according to information from the local tourist office, was named after the first naval physician from 1814-1835, Dr Alexander Denmark. I visited Denmark several times from my base in Albany to familiarise myself with the area, to interview GPs and their spouses and to meet local

---

<sup>2</sup> For extended history of its construction see <http://www.bibbulmuntrack.org.au/history.asp>

residents. It is another place of great natural beauty, built along the Denmark River and around Mount Shadforth and the Wilson Inlet. The shire is a popular tourist destination and offers a variety of scenery from a rugged coastline to forested areas, including the Walpole Nornalup National Park, to vineyards. The shire covers an area of 1842 square kilometres and has a population of about 5600 and medical services are provided by eight GPs from two separate practices. The main street of the town outside the main tourist season conveys an air of sleepiness with few people congregating and several shops empty until the next holiday season. Denmark is a popular place for those wanting to live an alternative lifestyle (See Table 3 for a synopsis of information on the GSDGP).

**Table 3 Snapshot of the shires in the GSDGP**

Rural city (C) town(T) shire(S)	Area sq.kms	Distance ex Perth (kms)	Distance ex Albany (kms)	Population (ABS 2003 estimates)*	Industry	GPs
Albany (C)	4804	405	0	31 550	Regional cultural and service centre, tourism.	31
Jerramungup (S)	6451	454	176	1199	Fishing, fish processing, agriculture mainly broad acre farming but also grain cropping, sheep, timber plantations, vineyards and seed potato farms. Tourism around Bremer Bay.	1
Ravensthorpe (S)	13 553	532	293	1436	Broad acre farming, meat, wool, nickel mining, tourism.	1
Lake Grace (S)	9245	347	261	1558	Farming: wheat, canola, oats, barley, lupins and various legumes. Also sheep for wool and meat; yabbies (freshwater crayfish), wine grapes and oil mallees.	1
Kondinin (S)	7340	279	360	993	Farming wheat and coarse grain; sheep and wool and tourism (Wave Rock).	1
Boddington (S)	n/a	128	318	1421	Farming; coarse grain producing area and sheep. bauxite mining, small farming eg marron, flora culture, horticulture, ostriches, alpacas.	1
Pingelly (S)	1294	158	320	1179	Farming: mixed grain, sheep, cattle and pigs. Also yabbies, market gardens, emus and ostrich farming and wine grapes.	1
Narrogin (S)	n/a	192	281	765	Farming mixed grain and sheep.	
Narrogin (T)	n/a	192	281	4671	Service town.	7
Wagin (S)	1950	229	222	1836	Farming mainly mixed grain and sheep. .	1
Katanning (S)	1523	280	170	4433	Service town; pastoral, mixed grain with high production of cereal grain; sheep, halal meat works.	4
Gnowangerup (S)	5000	356	165	1495	Farming: mixed grain including wheat and canola as well as peas and faba beans, livestock, tourism	1
Kojonup (S)	n/a	256	154	2228	Farming: mixed grain and sheep.	1
Plantagenet (Mt Barker) (S)	4800	360	47	4500	Viticulture, horticulture and agro-forestry. Farming: cereal, oil and legume crops, tourism, livestock, orchards, commercial tree farms.	4
Denmark (S)	1842	400	51	5051	Tourism, viticulture, dairy farming.	8

Source: Information obtained from Regional Population Growth, Australia and New Zealand, 2002–03 (ABS cat. no. 3218.0) and Population by Age and Sex, Western Australia (ABS cat. no. 3235.5.55.001) and rural shire council websites.

Forty seven kilometres north of Albany is Mount Barker in the Shire of Plantagenet which I also visited several times while being based in Albany. It is located in an agricultural region with a population of 4500 and four GPs offer

their services from one general practice located in Mount Barker. The town gives the impression more of a service centre for farmers rather than one that offers much for the tourist. However, this area is renowned for its world class wines and the vineyards around Mount Barker are a significant drawcard to attract visitors and help boost the local economy.

Following my stay in Albany, I drove to Katanning where I stayed for a few weeks. I used it as a base to meet local GPs, spouses and community residents and visit neighbouring towns such as Gnowangerup. Katanning is located 170 kilometres north of Albany and 280 kilometres southeast of Perth and the shire covers an area of 1523 square kilometres. It is the largest stock selling centre in the Western Australia and is renowned for its cereal grains ever since the first flour mill was built in the town in 1891. It has a population of about 4400 and four GPs, all of whom trained overseas, provide medical services. Walking down the main street I was struck by a sense that the town was in decline. Vacant shop windows and peeling paint on shop fronts gave the impression of the place being in a state of disrepair. In the main centre there was one coffee shop tucked away in a dingy mall where several adjoining shops were empty or closed. However, this depressed façade to the town did not match the vibrancy and friendliness of local residents. Community groups were active and innovative and residents I spoke to were committed to maintaining the viability of their town. Locals were able to choose from a variety of activities that included opportunities to play various sports, to worship at one of the 12 churches and one mosque or to attend exhibitions at the local art gallery adjoining the recently built library. A cultural mix of Anglo-European Australians, the local Nyoongar Aboriginal community and a small but significant Malay population, who were predominantly Muslim and many of whom were employed in the local halal meat works, added to town's diversity.

The Nyoongar people come from southwest of Western Australia and, prior to British settlement, were the recognised owners of their land. Their nearest neighbours were the Yamitjis to the north and the Wongkis to the east. Their cultural and religious beliefs were linked to their land and they believed that the Rainbow Serpent, the Wagyl, was their creator and the guardian of their sources of fresh water while they, the people, were the guardians of the land. The

Wagyl is currently the symbol used on the Bibbulmun Track to direct walkers along the path. Some of the Nyoongar groups living in the southwest included the Wordung, Mainitich, Bullaruck, Rarraruck, Didiriik and Tondariik and the Bindjareb, all part of the Bibbulmun people (Van den Berg, 2002). While Nyoongar people spoke the same language, there were many dialects. Research indicates that 13 linguistic groups lived in southwestern Australia though the groups' names differed from those compiled by Norman Tindall in 1940 (Green 1984 cited in Van den Berg, 2002: 6).

By the early twentieth century and after nearly one hundred years of white settlement, divisions between different ethnic groups were obvious. The social position of early white landowners in the area was symbolised by the Katanning Club. This gracious federation homestead complete with wide verandas, high ceilings and stained glass windows was located close to the town centre. Constructed in the early 20<sup>th</sup> century it was a 'members only' club and became a bastion of the white male establishment where landowners could go to have a drink and play cards when they came to town and meet those of the same ilk. Women were not admitted to the club except on 'Pigs and Ladies Day' (in that order) when farmers brought in their wives who could 'freshen up' before going out, having come straight from the farm. Women were eventually able to join years later where they formed their own club, the Marloo Club in the same building. Even now, as the homestead falls into disrepair, club rules apply and only members and invited guests are admitted.

From Katanning, I drove south to Gnowangerup past misty grey views of the Stirling Ranges, a rugged rocky outcrop with five peaks rising above 1000 metres that is a popular ecotourism spot providing the only alpine walks in Western Australia. Gnowangerup is about 60 kilometres southeast of Katanning deep in the heart of sheep and mixed grain growing country and about 360 kilometres from Perth. It is an area renowned since 1908 for stud merino sheep. The population of Gnowangerup Shire is nearly 1500 and one GP offers services in the area. Within the shire are the towns of Gnowangerup, Borden, Ongerup and the Stirling Range National Park. The town has wide open streets that add to its sense of space. A recently opened coffee shop, The Blue Baa, known locally as The Blue Bra, is run by two women residents who do the cooking. Sipping

one of their excellent cups of coffee, I noticed that everyone who enters the shop is generally known by name and greeted cordially as conversations ensue about crops, weather, family and gossip.

North-east of the City of Albany boundary is the Shire of Jerramungup which is 430 kilometres southeast of Perth. The shire began in 1982 and currently has a population of about 1200. A solo, overseas trained GP offers medical and pharmaceutical services from the main surgery four days a week in the town of Jerramungup. He also provides clinics at the branch surgery in Bremer Bay which otherwise operates as a nursing post. Bremer Bay is a popular tourist destination on the coast with the population swelling from 250 to over 5000 during peak season (South West People Care, 2002). The Jerramungup shire includes the towns of Jerramungup, Bremer Bay, Needilup, Gairdner, Boxwood Hill and Jacup.

The main highway from Jerramungup to Ravensthorpe is flanked to the south by the Fitzgerald River National Park, an area designated in 1978 as one of Australia's twelve biosphere reserves under UNESCO's Man and the Biosphere programme. A biosphere reserve is founded on the concept of people living and working with the environment in a sustainable way (SMEC Australia Pty. Ltd., 2002). Ravensthorpe, or Ravy is it is known locally, is nearly 300 kilometres east of Albany and 530 kilometres southeast of Perth. The town with a population of 350 people nestles in the Ravensthorpe hills that surround it to the north, east and southeast. The town enjoys expansive views of a patchwork of fields in plains spreading out towards the coastal town of Esperance. Ravensthorpe has a lively atmosphere and local residents are friendly and welcoming. The main surgery in the town offers the services of one overseas trained GP. Medical services are also provided at a clinic in the quiet, coastal town of Hopetoun with a population of 320 where I stayed in the local caravan park, in the hope of seeing any passing pods of whales making their way westwards. However, the place was deserted as strong winds and three cold fronts buffeted the coast, a fact which may have also have deterred the whales. The shire of Ravensthorpe covers an area of 13 553 square kilometres with 242 kilometres of sealed roads and about one thousand kilometres of unsealed roads. Two thirds of the shire remain as natural bushland,

including the Fitzgerald River National Park. Evidence of its mining history is seen in abandoned mine shafts dotted about the area.

After a couple of days in Hopetoun I drove north-westwards to Lake King and Newdegate along a seemingly dead straight road on my way to Lake Grace which is located on the eastern edge of sheep and wheat farming land. I passed through mixed grain country where deep green fields of wheat stretched as far as the eye could see alongside splashes of yellow canola crops. The rainfall was noticeably less here with dried up river beds and salt lakes marking the landscape. There were few trees with mainly low-lying shrubs or ground cover. Sheep became more evident on the outskirts of Newdegate. The Shire of Lake Grace covers an area of 9245 square kilometres and stretches from Tarin Rock in the west to Hatters Hill in the east. It has a population of about 1500, and the town of Lake Grace has a 13 bed hospital and a new medical centre built in 2000 for the services of a doctor and dentist. One overseas trained GP is provided with premises to offer surgeries at Lake Grace and Newdegate.

I drove from Lake Grace to Hyden, east of Kondinin, an empty road with vast tracts of open plains interspersed with salt lakes in relatively flat country. Kondinin is located in pastoral country about 100 kilometres north of Lake Grace. The town offers agricultural services although many retail shops were empty in the main part of the town. Kondinin Shire comprises 7340 square kilometres and forms part of the eastern wheat belt of Western Australia. It includes the towns of Kondinin, Hyden and Kalgarin with an overall population of nearly 1000. One overseas trained GP serves the area and offers surgeries in all three towns. Hyden draws the tourist dollar because of its proximity to Wave Rock, a few kilometres to the east. This is a significant attraction considered by geologists to be a freak rock formation sculptured in the shape of a wave and coloured by chemicals and wind over millions of years.

Pingelly, 173 kilometres southwest of Kondinin, began as a shire in 1961. It is an attractive town situated in well established pastoral country covering an area of 1294 square kilometres about 280 kilometres southeast of Perth with many impressive federation style buildings. I drove to Pingelly whilst being based in the service town of Narrogin, about 50 kilometres away. Pingelly offers

the services of one overseas trained GP who holds his surgery in the local hospital and draws patients from the nearby shire of Brookton and smaller outlying locations such as Popanyinning, a hamlet on the Hotham River.

About 90 kilometres west of Pingelly is the town of Boddington which was an easy drive from Narrogin. It has a population of about 1400 served by one GP. Boddington was gazetted as a town in 1921 and is about one and a half hours' drive from Perth. This area offers a diverse landscape of rivers, wooded areas, state forest, undulating pastoral land and small hobby farms. A nearby bauxite mine offers employment. There is a noticeable presence of young people and three hundred students attend the local district high school.

A fifty kilometre drive south of Pingelly took me through rich agricultural land to the service town of Narrogin with a population of nearly 5000. The town was gazetted as a municipality in 1906.<sup>3</sup> Narrogin is located in a prosperous farming region that produces grain, sheep, pigs and cattle and supports a substantial sheep and stud breeding industry.<sup>4</sup> It is a vibrant town 192 kilometres from Perth and 280 kilometres from Albany. Narrogin is situated in a high valley and offers a variety of services and retail outlets including several restaurants and cafes, a library, and a strong sporting culture. It exudes an air of prosperity that is reflected in well preserved, gracious federation homes and commercial buildings, few empty shop fronts, well-kept gardens, an impressive hospital and no less than four coffee shops in town. The Dryandra Woodland north of Narrogin is 28 000 hectare bush sanctuary for the conservation of wildlife including the rare numbat and woylies. This conservation area also attracts tourists and offers self-contained accommodation in traditional workers' cottages and facilities for camping, bush walking and cycling. Eight GPs, most of whom trained overseas, offer surgeries from two general practices.

Wagin is located in the middle of two service towns, Narrogin and Katanning. It is situated in rich pastoral land where I drove through a patchwork of colour in spring between fields of golden canola, bright green wheat shoots

---

<sup>3</sup> See <http://www.narrogin.wa.gov.au/> for more information

<sup>4</sup> See <http://westregional.com.au/papers/no/>

and brown fallow land. This gracious town with the ubiquitous wide streets flanked by impressive federation buildings includes an old colonial pub on the corner of the main street which doubles up as a restaurant and coffee shop. The population of Wagin shire is over 1800 and the town is located within the shire, an area of 1950 square kilometres. Medical services in the shire are provided by a solo, overseas trained GP who works in a brand new, light filled surgery as part of a health care centre.

On the main Perth to Albany highway over 150 kilometres north of Albany is the town of Kojonup in the midst of prime sheep country and rolling pastures of mixed agricultural farming. Kojonup has a population of over 2200 many of whom contribute to the local community newsletter informing residents of various activities in which the community is involved. Like other rural shires with small populations, one solo GP provides surgeries in Kojonup and also offers limited medical services in the local district hospital. Kojonup also has a district high school for students up to Year 10. According to one local resident, many of the youth leave the town 'as there is nothing for them here'.

## **History**

The southwest of Western Australia formed part of a large cultural block that covered land occupied by the traditional Indigenous owners, the Nyoongar. The land around Albany was part of the traditional country of the Minang group. Members of this group had little immunity to diseases introduced by British settlers with many dying from the common cold, whooping cough, flu, measles and tuberculosis (Day, 2000).

Albany is the oldest European settlement in Western Australia and was settled by the British in 1826 following orders from London to the Governor of New South Wales to secure the area after repeated sightings of French vessels off the coast. Settlers arrived by the Brig Amity on Christmas Day led by Commandant Edmund Lockyer (Day, 2000). Albany was declared a military outpost in 1827. It was not a penal settlement and the first free settlers arrived in 1831. In 1832 Governor Stirling officially named the settlement Albany after the Duke of York and Albany. Albany was originally a major whaling station and shipping port: the whaling station opened in 1835 and Albany's first exports to

London were whale oil, sealskins and wool. By 1851 Albany had become the mail port of Western Australia which led to a boost in the local economy and port facilities being upgraded. Convict labour built the road from Albany to Perth in 1853 and contributed to the expansion of the labour force and local economy. This was further boosted by the construction of the Great Southern railway which was opened in 1889 and led to an increased demand in the burgeoning local timber industry (Day, 2000).

Between 1900 and 1928 large tracts of land were subdivided and offered to British migrants to encourage them to settle in the southern part of Western Australia. However, the Great Depression led to widespread unemployment and full employment did not return till after the Second World War. By the 1960s, key elements in the Australian economy were agricultural growth, expansion and development. The Albany to Perth rail service closed in 1978, replaced by a bus service as road travel became easier with bitumen roads. In the 1970s, agriculture began to diversify as a result of low wool and beef prices. Tourism began to expand and new schools were built around this time (Day, 2000).

The first hospital was built in Albany in 1829 and the current hospital was opened in 1962 (Walker, 1963). Dr Alexander Collie, who lived from 1793 to 1835 was a surgeon and the first government resident in Albany after control of the settlement had been transferred from New South Wales to Western Australia (Johnson, 2001). Early medical practitioners in Albany had a dubious history. In 1868 Dr Cecil Rogers was the local doctor and health officer for Albany and was well known for being 'obnoxious' and 'had little time for his patients' (Garden, 1977: 166). In the 1850s and 1860s local doctors William Finer and Johannes Antonius Baesjou suffered from deep depression and went insane allegedly as a result of the community's lack of faith in their medical expertise. Finer was taken to an asylum and Baesjou slit his own throat.<sup>5</sup> Little is known of the provision of medical services in areas other than Albany at that time.

---

<sup>5</sup> Garden (1977) accesses this information from the Perth Gazette Newspaper 20.5.63 and the CSO (Colonial Secretary's Office) 256/107.

European settlement of townships began at various points during the nineteenth century. The area around Jerramungup was explored by the surveyor, John Septimus Roe in 1848 on his way to Esperance. The second part of the 19<sup>th</sup> century and much of the twentieth century saw conflict between white settlers and the local Aboriginal people, wandering sandalwood cutters and itinerant drovers.

The township of Jerramungup did not come into existence until 1957 after the Hassell family, the original British family who settled in the nineteenth century and farmed the land, sold their large farming property in 1950 to the Land Settlement Board.<sup>6</sup> The area from Jerramungup to Ravensthorpe was littered with disused mine shafts reflecting its gold mining history. Copper mining also contributed to the local economy until it ran out in the 1960s. However, mining in the area led to the development of a port at Mary Ann Haven, later Hopetoun, and a rail link between Hopetoun and Ravensthorpe. The disused rail track is now a popular walking spot. In 1868, Ravensthorpe and the area around Hopetoun were first settled by the Dunn brothers who began a sheep station assisted by Aboriginal shepherds.<sup>7</sup>

Historical information accessed from local websites, town libraries and tourist bureaus visited en route revealed that John Septimus Roe also explored the country around Lake Grace and Kondinin in the late 1840s and was assisted by the local Aboriginal community. The land in this area was eventually settled by pastoralists and was opened up in early 1900s for sheep and timber production, including sandalwood and wheat. The town of Kondinin was founded in 1909. Several hundred kilometres to the southwest, the first settler arrived in Pingelly in 1846 and farmed 4000 acres. Permanent settlement began in 1860. The Perth to Albany railway led to an economic boom in the area and by 1898 the population of Pingelly was 350. Local industry included farming, sandalwood, mallet bark and animal skins. The Pingelly shire council was formed in 1961.

---

<sup>6</sup> See <http://www.walkabout.com.au/locations/WAJerramungup.shtml>

<sup>7</sup> See: [http://www.travelmate.com.au/Places/Places.asp?TownName=Ravensthorpe\\_%5C\\_WA](http://www.travelmate.com.au/Places/Places.asp?TownName=Ravensthorpe_%5C_WA) and <http://www.accommodationguide.com.au/sitemap/racv/Golden-Outback-ravensthorpe.shtm>

The larger town of Narrogin emerged as an important centre in the late 1880s and became a major rail link during the construction of railways to Albany, Beverley, Collie, Wickepin, Kondinin and Dwarda. Narrogin attracted agricultural service industries as well as government departments and agencies. Boddington, to the west, was gazetted as a townsite in 1912. From 1937 commercial tannin production from white gum timber was one of its main industries. Narrogin was gazetted as a municipality in 1906 and remained a major rail centre until the late 1970s when competition from road transport and improved roads reduced the railways workforce from 280 people to less than a dozen in 1995.<sup>8</sup> White settlers began arriving in Wagin from 1840 and the town of Katanning was founded in 1889 when the Great Southern railway between Albany and Perth was completed. Drovers and shepherds also arrived in the area following the sandalwood cutters. New settlers were attracted to fertile farmland in the early 1900s particularly as both commodity prices and the demand for labour were high. Small communities around the town also flourished. After the Second World War cultural diversity increased as European migrants came to the town looking for work. Malay people from Cocos and Christmas Islands also settled in the area.<sup>9</sup>

Sandalwood cutting was also an early industry in Gnowangerup, southeast of Katanning. Information from the Shire of Gnowangerup, which drew on research by Merle Bignell in her book *The Fruit of the Country*, indicates that the meaning given to Gnowangerup by the local Nyoongar people was 'place of the mallee fowl'. Traces of Aboriginal history are also evident in the stone implements found along the creeks. Such finds suggest that these areas formed some of the hunting grounds of the Goreng Nyoongar. During the nineteenth century, sandalwood cutting played an important role in the shire's history. A sandalwood cutters' camp was established at Borden in the 1840s about 35 kilometres east of Gnowangerup.

---

<sup>8</sup> See: <http://www.narrogin.wa.gov.au/> for more information.

<sup>9</sup> Information from tourist bureau and informal discussions with local residents and also from <http://www.katanning.wa.gov.au>

Several years after the founding of the Swan River Settlement in 1829,<sup>10</sup> later Perth and Fremantle, Alfred Hillman was sent north by Governor Stirling to blaze a trail from King George Sound (Albany) via York to the Swan River Settlement. He was guided by local Aboriginal people to a freshwater spring in what is now Kojonup. His favourable report back to Governor Stirling resulted in setting up a military outpost to protect travellers and the mail. European settlers were first attracted to Kojonup in 1837 because of the availability of fresh water. The word 'Kojonup' is a derivation of the Aboriginal word 'koja' meaning 'stone axe'. Overlooking the spring is the old Military Barracks, constructed in 1845 and one of the oldest surviving military buildings in Western Australia.<sup>11</sup>

South of Kojonup and east of Mount Barker is the Stirling Range, which was named by John Septimus Roe in 1835 after first Governor of Western Australia, Captain James Stirling. Governor Stirling explored Mount Barker in 1831 and a military garrison was stationed there in the 1830s. The town, like many others, developed further with the construction of the Albany to Perth road and railway lines. Given the temperate climate of Mount Barker, apples contributed to the early growth of the town.

Information from the local tourist office and library indicates that there is also archaeological evidence of Aboriginal occupation in the area around Denmark. Low stone walls, possibly around 3000 years old were found in the Wilson Inlet in Denmark and were used by local Aboriginal communities to trap fish. Stone chips have also been discovered in places where stone tools were made. The town of Denmark was established in 1895-1896 by white settlers, mainly because of the huge demand for timber for export to the United Kingdom and Europe, Africa, India, China and the United States of America. By 1905, the forest had been felled which eventually led to closing down the mills and Denmark became a virtual ghost town. Early settlers began farming in 1906 and established vegetable gardens and orchards for home consumption and income and by 1911 dairy farming began as an industry. The 1920s saw the beginning of

---

<sup>10</sup> See: <http://www.newmanjunior.wa.edu.au/West/swan.htm>

<sup>11</sup> See: <http://www.kojonup.wa.gov.au/html/kojonup.htm>

the tourism industry. More recently, after the Second World War to the mid 1970s, cattle grazing on former dairy farms began. Sheep were also introduced and the timber industry recommenced in response to the building boom. From the 1980s, in the face of rural decline, Denmark's population increased to become one of the fastest growing population centres in the Southwest of Western Australia. It was seen as an attractive location for retirees or those interested in farming on small rural properties and people preferring an alternative lifestyle. Agricultural diversity continued with an increase in the land used for vineyards and growing wildflowers (Conochie, 1990). It also became a popular tourist destination.

### **Rural economy**

The Great Southern region of Western Australia currently has a mixed economy drawn mainly from sheep and mixed grain farming, viticulture, and, to a lesser degree, mining and fishing (Great Southern Development Commission, 2003). The region is a premier producer of fine wool and is the second largest wool producing area in Western Australia as well as being the state's second largest meat producer, mainly from the slaughter of sheep and cattle. Its primary industries include broad acre cropping, wool, livestock, horticulture and fishing all of which constitute the mainstay of the economy. Other crops include grapes to support an expanding wine industry in specific areas around Albany, Mount Barker and Denmark. Aquaculture is also being developed in addition to fishing. Land is also used for blue gum plantations which have increased in popularity as a commercial venture. The manufacturing industry supplies equipment and machinery to the farming sector and processes agricultural commodities. After sharp falls in 2000-1 the construction industry is recovering and commercial activity in the region has been expanding. Tourism continues to show strong economic potential for the future (Great Southern Development Commission, 2003).

Many areas in the region outside Albany run sheep and harvest mixed grain crops. Some local economies are diversifying with Jerramungup operating a fish processing plant and Lake Grace occasionally harvesting yabbies or freshwater crayfish as well as growing grapes for wine. The mixed grain and

sheep farming has also diversified in Boddington and Pingelly where ostriches, emus and alpacas are farmed. Katanning, as the largest stock selling centre in Western Australia, also produces high yields of cereal grains and has opened an halal abattoir where many in the local Muslim Malay community now work. Mining operations for Silica sand and spongolite are carried out in the area (Great Southern Development Commission, 2003) and a nickel mining operation is soon to commence outside Ravensthorpe. While Boddington is noted as a top wool and coarse grain producing area, it is also mined for bauxite and gold. Information from the Shire of Kojonup reveals that new initiatives have been implemented such as the Recycling Program and the Kojonup Soils Centre that is being developed in partnership with the University of Western Australia. It offers an unbiased soil analysis service for farmers on a commercial basis.

Tourism is developing in the region covered by the GSDGP even in the more remote locations. The coastal areas from Walpole in the west to Hopetoun in the east are popular destinations and the natural beauty of the Stirling Ranges and the Porongurups, an area dominated by karri forest, is also a drawcard to explore inland areas. The Gnowangerup Aboriginal Corporation offers tours of Koik-yen-nuruff (Stirling Ranges) that focus on the cultural heritage and history of the Nyoongar people in that area, as well as information about bush foods and traditional medicines.<sup>12</sup> Less well known tourist destinations are the more isolated areas. Kondinin draws the tourist dollar with the proximity of Wave Rock, a local geological attraction which is also important in local Aboriginal history as a site of cultural significance. The area around Lake King and Lake Grace offers windsurfing on the salt lakes. Information about local activities in many rural shires is available in community newsletters which are published locally in many of the small towns. The *Wagin Community Profile* informs the reader about some of the tourist attractions in the area including the Historical Village where original buildings have been either relocated to this site or recreated. It is staffed by volunteers and attracts fifteen thousand visitors

---

<sup>12</sup> See:  
[http://www.albanygateway.com.au/Town/Gnowangerup/Gnowangerup\\_Aboriginal\\_Corporation/](http://www.albanygateway.com.au/Town/Gnowangerup/Gnowangerup_Aboriginal_Corporation/)

annually. Wagin also hosts the Woolarama, claimed to be the biggest sheep show in the southern hemisphere. It is an annual event that attracts 30 000 visitors.

Kojonup has recently opened 'The Kodja Place', a tourist attraction built around the theme of 'one story, many voices'. Mixed media displays present local Nyoongar culture intersecting with the rural history of white settlers in the area, particularly those from Britain and Italy.<sup>13</sup> Viticulture is centred round Mount Barker, Denmark and Albany and wine tasting is a favourite pastime with tourists. Information from the Plantagenet Shire Council claims that the shire is the largest wine growing area in the state where more than 1000 hectares of vines have been planted and all major grape varieties are represented. Farming has also further diversified from mixed grain and sheep to the increase in the timber industry with tree plantations occupying 780square kilometres or 22 per cent of freehold land in the shire. Mount Barker is situated in area of high biodiversity with a broad range of ecological species including karri forest, jarrah, marri and white gum woodlands and sand plains.

## **Rural restructuring and development**

While the populations of many inland and agricultural areas are decreasing (Tonts, 2004) those of the shires of Denmark and Plantagenet and the City of Albany are increasing. These three local government areas accounted for 76.3 per cent of the population of the Great Southern region in 2002 which is predicted to increase to 81 per cent by 2011 (Great Southern Development Commission, 2003). Using data from the ABS analysis of the 2001 Census, the Shire of Denmark 2003 *Local Planning Strategy* recorded that the population of Denmark increased by 18.2 per cent from 1996 to 2001 census compared to Albany which grew 9.65 per cent and the Shire of Plantagenet which grew by only 5.1 per cent. Other inland populations fell; Katanning by eight per cent and Kojonup by just over three per cent.

In rural areas, services are a 'significant element of community vitality and prosperity' (Cocklin & Alston, 2003: 2). Notwithstanding population

---

<sup>13</sup> See <http://www.kodjaplace.net.au>

decline, certain services are currently available in all shires including state primary schools for children up to Year 7. Albany offers more choice between private and public education. There are several primary schools, three senior high schools, colleges of Technical and Further Education (TAFE) and a recently opened University of Western Australia campus offering several undergraduate degree courses in Albany. Opportunities for post-secondary education and training are also offered through TAFE colleges located in Katanning, Narrogin, Mount Barker, and Pingelly.

Outside Albany, all but one shire has a District High School for students from Years 8 to 10; students from Kondinin shire have to travel to attend school in Kulin in the neighbouring shire. Some shires including Denmark, Gnowangerup and Narrogin also offer secondary education in agricultural colleges some up to Year 12. Buses are often provided for students not living in the areas but who choose to attend Years 11 and 12 in Senior High Schools. Senior High Schools are also located in Narrogin, Katanning and Mount Barker. Narrogin Senior High School has 850 students including 240 from the environs who stay in a local residential college. Katanning also has a residential college for students from out of town though numbers are lower than in Narrogin. Some parents choose to send their children as boarders to a private school in Perth, usually for their secondary education.

Community participation in local activities forms a significant aspect of life in rural locations and contributes to the sustainability of rural towns. Activities that range from sport, to supporting local schools and hospitals, to recreational pursuits including arts and crafts, to worshipping at local religions institutions are some of the areas of interest. In Kondinin there are over 30 different community groups offering social support and a sense of belonging from activities that include meals on wheels to the local gardening club. The town of Kondinin with a population of about 300 offers at least 15 sporting clubs. Boddington provides six floodlit hard tennis courts for the community, a swimming pool, an 18 hole golf course, three netball/basketball courts, a full size grassed oval for cricket, hockey and football and another smaller one, a pony club, rifle range, cricket practice nets, two bowling greens and facilities for badminton. Wagin offers 54 clubs or organisations, 23 are involved with sport,

including the aero club and the trotting club. Sporting facilities in the town include a six lane, 50 metre swimming pool, ten tennis courts, a bowling club, a trotting track, facilities for go-karting, hockey, netball, horse trials, basketball and badminton. Narrogin has over 60 sport and recreation clubs, including football, tai chi, a repertory club and a clay pigeon shooting club. Service clubs such as Rotary or Apex are also well represented. Pingelly offers at least 18 sports and recreation clubs and six Christian churches to sustain a shire population of about 1200. Narrogin has 13 Christian churches or places of worship as does Katanning. Katanning recently built a new public library to which is attached an art gallery offering exhibitions and space for local and national artists to display their work.

Rural communities also want adequate provision of health care services where having a local GP is considered a top priority. While there were 60 GPs working in the GSDGP when this research was undertaken, their main surgeries were located in 14 of the 25 shires in the region. GPs mostly worked in private practice with one exception where the GP only bulk billed his patients. Bulk billing allows patients to allocate their Medicare rebate directly to the GP who accepts the rebate as full payment for his/her services (Australian Government Department of Health and Ageing, 2005). General practices elsewhere can selectively bulk-bill their patients. Emergency and aged care are often available in District hospitals in all shires offering GP services. Individual GPs can apply to the Health Department of Western Australia for visiting rights to the local hospital in the location in which they work. However, procedural work such as obstetrics and surgery is only available in larger centres. The City of Albany offers a 120 bed hospital that provides residents in the region with specialist services including surgery, chemotherapy, obstetrics, mental health, rehabilitation, paediatrics and day procedures as well as a comprehensive range of outpatient clinics including cardiac rehabilitation, endoscopy and specialist wound care. The majority of patients in the hospital are under the care of their local GPs.

While many rural communities are seeking the services of a GP, medical services in Narrogin are not considered a problem by the local shire council. The success of the town is such that the shire has offered few incentives similar to

those provided by other rural shires such as free housing to attract and keep GPs. Instead, GPs have generally arranged their own accommodation and surgery premises. Several GPs who have worked in the town have stayed over ten years, some over twenty years. There are no salaried doctors working at the 51 bed district hospital and all local GPs have Visiting Medical Officer (VMO) rights to attend their patients at the hospital. Recently one of the practices applied for funding as an area of unmet need to attract the services of another GP. This was granted and hence the practice was able to offer subsidised housing to the incoming overseas trained doctor.

Many smaller hospitals outside the large and medium rural centres have been downgraded in the current political economic climate although they continue to offer reduced services. Kondinin has eight beds, five for acute care and three are allocated as nursing home beds. It also offers 24 hour accident and emergency services, minor surgery, paediatric, ante-natal, post-natal and aged and extended care. There is also a modern 18 bed accredited hospital in Wagin which includes a palliative care ward and a hostel for the frail aged located next to hospital. Gnowangerup District Hospital was built in 1930s and has 17 beds. It offers emergency medical care, allied health and an aged care unit which has its own vegetable garden tended by residents. Kojonup also has a local hospital and facilities for the aged.

## **Providing rural health care**

Discussion with one resident stallholder at the local Saturday morning markets in Albany centred on his perception of the lack of government support for the sustainability of rural communities. Greg (pseudonym) was concerned that governments failed to appreciate the effects of rural restructuring and development on the social fabric of local communities. He argued that reducing services in rural locations did lead to job losses and people leaving to find work elsewhere, a move which effectively threatened the viability of some of the smaller towns. As populations dwindled, keeping local businesses commercially viable became more difficult. This sometimes resulted in amalgamating services with other smaller communities which, he thought, undermined discrete communities' sense of belonging to, and identity with, 'their' town. Greg saw

this development as further evidence of governments making it more difficult to attract new businesses, let alone GPs, to work in areas where this downturn was occurring. Greg's comments draw attention to the wider effects of political and economic changes on social practice in rural communities

In order to understand the process of recruiting and retaining GPs more specifically, I contacted those directly involved at the local community level. This led to discussions with six Chief Executive Officers (CEOs) of local shires in the GSDGP and two shire councillors as well as six Health Service Managers/Directors of Nursing (HSM/DONs) who worked closely with GPs. I also met local representatives from health services, community development and several community residents in order to discuss their responses to the recruitment and retention of GPs and their families. These discussions provided a broader understanding of issues relating to the delivery of rural GP services and an opportunity to reflect on hegemonic views regarding medico-centric approaches to rural health care delivery. In this context, differences emerged within and between groups regarding the solution to the rural health problem being one of providing more doctors.

Several CEOs of rural shire councils and HSM/DONs commented that the capacity to provide medical services locally constituted a significant drawcard for people to live in the area. It also had the added advantage of attracting others to the area to use the medical services. One CEO commented that, without a GP, local residents attend medical services elsewhere and inadvertently undermine the commercial viability of their own town by patronising other businesses in the town where the GP is located. This is particularly relevant when considering the effect of neoliberal policies on the restructuring and development of some rural centres where hospitals have been downsized and services such as banking reduced or closed as populations dwindle (Cocklin & Alston, 2003; Tonts, 2000). Such structural changes affect the lives of those already living in the area and impact on people's decisions to move to the area.

Banks and other businesses that withdraw services not considered economically viable appear to lack an awareness of the social costs to the

community. Job losses may lead to out-migration if employment opportunities are unavailable. The viability of the community itself may be at risk particularly in isolated locations where residents have to travel further to access a range of services. Attracting GPs is made more difficult if the social and economic fabric of the community is compromised as a result of rural restructuring. This presents a challenge to many rural shire councils who want to attract the services of a GP and find ways to keep them in their area.

Rural shire councils are involved in recruiting and retaining GPs. Historically, many were responsible for recruiting GPs themselves, an expensive and time consuming exercise with no guarantee that the GP would remain in the area. One CEO commented that advertising alone could cost thousands of dollars and, if the GP decided to leave, the process would have to be repeated. Costs to recruit and retain the services of a GP came out of the overall annual budget already allocated to the local shire council by the state government. According to another CEO, local government receives insufficient resources from state and federal governments to ensure medical services are run effectively. He argued that, in the current political and economic climate, the state and federal governments saw the bottom line in economic rather than social terms. In other words, he argued that their objectives were less about meeting the health needs of the local community in the most effective way, and more about shifting costs, balancing the budget and making cuts where necessary regardless of the social effects. He commented that this perspective highlights 'the difference between running a service and running a business'. Another CEO discussed the fact that money spent on GP services may leave a community with insufficient funds to provide other necessary services such as constructing and maintaining a sports oval that also contribute to the health and welfare of the community.

Several years ago, the process of recruiting GPs to work in rural locations often generated competition between shires where, according to another CEO, bidding wars ensued: shires with greater resources were able to offer more incentives to attract GPs and their families than those with a more limited budget. This process revealed the diversity among rural communities in terms of economic resources that often reflected deep-seated inequities in the capacity to provide medical services. In the last five or six years this method of recruitment

and retention has changed. Most of the smaller shires in the GSDGP, particularly those needing a solo GP, have enlisted the services of private industry where recruiting agencies will often guarantee to provide a GP for the community, shoulder the advertising costs of attracting a GP, often overseas trained, and sometimes take over the management of the general practice, including paying staff wages, leaving the GP free for clinical work. Recruitment agencies may also agree to find locums if the GP goes on leave. In return, the shire council pays the agency an annual fee of several thousand dollars and often provides the surgery premises in which the GP works. In addition, the shire council might negotiate with GPs incentives from its annual budget with incoming GPs and their families. These may include a rent-free house and car and, sometimes, payment of domestic utility bills. Four shires with solo GPs were in the process of constructing, or had already built, large, four or five bed-roomed houses or were renovating older houses at no cost to the GP. According to one CEO, the local GP's newly built home was 'one of the best houses in town'. Another shire also guaranteed the GP a minimum annual gross income in addition to providing him/her with a house. If the GP exceeded this amount, he/she was entitled to keep the profit; if not, the shire would pay the difference to the agreed amount. GPs were usually required to pay a percentage of their income to recruitment agencies for managing their practices.

One CEO approved of allocating a proportion of the annual budget to paying a recruitment agency to provide the local community with the services of a GP. The same CEO commented that a top priority for many rural communities was to have a local GP working in their town. Other CEOs looked at the issue more broadly and claimed that local GPs did not just provide medical services but contributed to the economic sustainability of rural towns. Not only did job opportunities increase in the health sector, but also people were more likely to want to live and work in the town if they knew medical services were available. Without such services one CEO commented that residents went elsewhere to access medical care. This often led to residents using other services in the town where the GP was located, such as shopping for food and fuel, which drained the local economy of their own town.

HSM/DONs' involvement in recruitment and retention of GPs varied. While some actively participated in strategies to attract and keep doctors working in their communities, others' contribution to the process was minimal. One HSM/DON fostered a spirit of collaboration and negotiation with local GPs, all of whom were overseas trained, by supporting them professionally, socially and economically. She commented that many OTDs from culturally and linguistically diverse backgrounds arrived with little financial capital and needed support till they established themselves and she encouraged community residents to participate in the process. This translated pragmatically into the HSM/DON working with the local shire council to find an appropriately located surgery building and the resources to refurbish it. The HSM/DON also suggested Rotary organise a dinner to welcome GPs and their spouses and introduce them to local community members. She encouraged local business to become involved in the process of helping GPs and their families settle in. This resulted in one local car dealer offering to offer cars to two new doctors where payments could be waived till they 'found their feet financially'. In another shire, the council regularly met the new GP with a view to looking after the personal welfare of the GP and his/her family and to 'check everything is OK'. One HSM/DON commented that, in the past, rural communities had expected local GPs to stay 'for ever'. While several GPs had practised in the same location for over 20 years, the HSM/DON suggested that such expectations were unrealistic. She regarded the higher turnover of GPs as 'not such a bad thing' given that new GPs brought new ideas and practices that could benefit the community.

CEOs and HSM/DONs incorporated other ways to encourage GPs to stay. These included attempts to modify community expectations that GPs were available whenever anyone was sick. This was no easy task. Medical care remains an important element in rural communities' notions of what constitutes health care. One HSM/DON commented that, in her experience, many people rely on the health system, including the GP to solve non-medical issues. She suggested that rural communities often sought responses to social problems from within the health system rather than seeking support from other sources such as the extended family or the wider community. She observed residents in the town in which she lived who expected 24 hour availability if they were sick or needed

help and felt they 'owned' the GP. She commented that if locals saw the GP's car in the driveway of his/her home, they would knock on the door and request his/her services. A CEO in another shire discussed the need to educate local residents about appropriate boundaries in their relationship with their GP. He suggested that if residents realised GPs needed time off in order not to become overloaded, and therefore more likely to leave, then they might change their behaviour and become less demanding of GPs outside surgery hours unless there was an emergency. Members of one shire council actively discussed with local residents ways to raise awareness of the issue and followed up with letters to the editor of the local newspaper. These strategies showed the commitment of local shires to encouraging the community to become actively involved in finding ways to persuade GPs to stay.

The issue of recruiting and retaining GPs could also be a site for contention. Informal discussions with local residents revealed that the dominant position GPs held in the health hierarchy, as well as their position of privilege within the social organisation of the community, sometimes created dissension. One shire councillor commented on the perception amongst some residents of the divide between doctors and the rest of the local population. She claimed that the generous financial inducements offered to GPs and their families to work in a rural location reflected their privileged status and set them apart from others in the community. Some residents of smaller rural centres raised the issue of inequity with comments that that rural GPs are given too much. They pointed out the lack of incentives offered to other professions and workers who also contribute to community sustainability. At the opening of an art exhibition in Albany, a fourth generation rural resident and shire councillor bemoaned the elitist treatment governments accorded rural GPs and discussed the notion that community sustainability rested as much on residents providing businesses and services that supported the viability of the town as it did in providing doctors. In one agricultural service town, this shire councillor commented that diesel mechanics were important but 'who offers them subsidised housing and a new washing machine?'

The need for the services of a GP at any cost was also contested amongst health professionals. One HSM/DON observed that, when the GP is not

available, the community uses the services of nurses at the local hospital or nursing post. Nurses often have back-up support from the GP who may be located in another town, the local hospital or the Royal Flying Doctor Service (RFDS) if necessary. However, the HSM/DON commented that rural nurses seldom receive adequate recognition for the work they do. Even with a local GP resident in the town, another HSM/DON mused that she assesses patients in hospital and informs the GP who phones through orders. As a result, she would take blood from patients, run electro-cardiographs (ECGs), insert intra-venous infusions and stitch up patients; services that were historically provided by GPs. A third HSM/DON questioned whether a GP was necessary in some smaller towns given their proximity to larger centres with medical services.

Discussions with HSM/DONs provided opportunities to consider innovative approaches to rural health care. While difficulties attracting rural GPs were understood, potential solutions ranged from employing government salaried doctors to work in rural hospitals to increased recognition of the role of rural nurses play in providing health services, particularly when a doctor is not available. Some HSM/DONs commented that employing salaried medical practitioners might generate tension amongst local GPs in private practice whose visiting rights to practise in hospitals and perform procedural work might be threatened. A major advantage of rural general practice and a source of professional satisfaction for many GPs was the opportunity to carry out procedural work on their patients. In this context, doctors were able to exercise their autonomy and take control of decisions regarding the care of their patients in hospital and maintain their own procedural skills. This process was unlikely if they lived in metropolitan centres where decisions about patient care in hospital were generally made by specialists. Some HSM/DONs commented that hospital work was also very lucrative for rural GPs comprising, on average, around one third of their overall income.

Individuals working in community development and health care in the Great Southern region discussed the notion of diversity between rural communities when considering health care needs. Some suggested that, rather than providing more GPs as a one-size-fits-all solution, exploring solutions 'outside the square' was also important. Suggestions included the increased use

of technology such as Telehealth which draws on electronic information and interactive communication technologies including video-conferencing to deliver health services to those living in remote locations with no access to GPs.<sup>14</sup> However, this approach presumes access to, and proficiency in, working a computer or other relatively expensive technology in a rural environment where telecommunication services are often less than adequate. Other suggestion was to find the best way to appropriately meet health needs given the demographic differences between locations. Responses included placing more emphasis on health promotion and recognising cultural differences when considering health needs. Evidence of the latter is found in the Great Southern Family Futures Program based in Albany which includes an Aboriginal Health program funded by the Office of Aboriginal and Islander Health whose aim is to provide a holistic approach to the health care of Aboriginals and their families. It is also seen as an opportunity for the Nyoongar people of the Great Southern to have a voice in the delivery of health care programs to their community. This highlights the benefits of using Aboriginal health workers for health education and health promotion in local Indigenous communities. Medical services were accessed from GPs in private practice or from the public hospital.

While other health professionals may offer alternatives to the medico-centric approach to rural health care, the hegemonic status of medical profession in the hierarchy of health care providers persists. This has sometimes generated tension between the rural GP and the local HSM/DON or shire councillors who were unable to meet the GPs' demands for resources owing to budgetary restrictions. Such tensions were explained by some CEOs and HSM/DONs as personality differences or 'clashes'. However, this response may only paint part of the picture thereby maintaining the issue at the level of individual differences. A social perspective paints a broader canvas whereby the notion of a dialectical relationship emerges between structure and social practice. By widening the lens with which to view the problem reveals its complexity and offers a more nuanced

---

<sup>14</sup> For further information see:  
[http://www.gpcg.org.au/index.php?option=com\\_content&task=category&sectionid=4&id=58&Itemid=1131](http://www.gpcg.org.au/index.php?option=com_content&task=category&sectionid=4&id=58&Itemid=1131)

appreciation of how structural factors can cause conflict at the level of practice. Political and economic constraints on the delivery of services may conflict with the ideas and practices of rural GPs about appropriate ways to respond to rural health care. For example, GPs working in private practice may want access to resources to provide optimum patient care. They may also want to maximise their income with minimal bureaucratic interference in their work practices. However, their work practices intersect with the public sector, the local hospital. The HSM/DON of the local hospital is allocated an annual budget from the state government for health service delivery and may want maximum efficiency, cost containment and 'best practice' in health/medical care which may restrict how the GP practises. This may result in tension between the GP and the HSM/DON who is restricted by limited resources. However, as discussed earlier, fostering collaborative relationships between HSM/DONs and GPs opens the door to negotiation and the potential for change.

It is at this point that I shift the focus to hearing the views of GPs and their spouses on factors that affect their sense of enjoyment living and working in rural locations and that underpin their decision to stay or leave. To set the scene, the next chapter discusses methodological issues that include the process of gaining access to GPs and their spouses, the gathering and management of information and the analysis and interpretation of ethnographic material.

## **CHAPTER 4**

### **Methodological matters**

The value of ethnography ... is found, not in its analysis and interpretation of culture, but in its decision to examine culture in the first place; to conceptualise it, reflect on it, narrate it and ultimately, to evaluate it (Van Maanen, 1988: 140).

With these comments in mind, I chose an ethnographic approach to examine the expectations and experiences of rural GPs and their spouses for two reasons. First, the work of Spradley (1979) gave me an opportunity to seek to understand, using a variety of methods, how participants experience and attribute meaning to aspects of their life that influence their decision to stay or leave rural general practice. Spradley's approach paints a picture of the world from the participant's point of view. I also chose to expand on this picture by providing a backdrop in which to situate and deepen my understanding of their world. The second reason I chose ethnography was to locate participants' expectations and experiences in a broader social context and 'subject the insider's view to critical analysis' (De Laine, 1997: 124). This perspective offered an opportunity to examine the role of structural issues in social practice and identify relationships of power. In this light, 'patterns of domination of individuals and groups that stem from fundamental structures and ideologies of social systems' (De Laine, 1997: 125), often accepted as part of the 'normal' social order (De Laine, 1997: 127), could be examined in relation to notions of hegemony and symbolic violence.

Ethnography combines the perspective of both the researcher and the researched and requires that the researcher participate in and observe participants' actions and behaviour in everyday contexts rather than in experimental conditions (Hammersley, 1990). Hammersley (1992) argues that the contextual nature of ethnography, and the time taken to develop rapport and trust with those involved, more than any other methodological approach, assists in understanding more fully the cultural rules, norms and beliefs of a specific group of people that inform their actions and behaviour. As a model to guide the study it allows the observer to 'conceptualise ... reflect ... narrate ... and

ultimately ... evaluate' (Van Maanen, 1988: 140) a particular social group who live and work in a rural setting in the context of structural changes. The group attracting my interest in this project were male and female Australian trained rural GPs, their spouses/partners, and overseas trained doctors (OTDs) and their spouses, living and working in diverse locations within the area covered by the Great Southern Division of General Practice (GSDGP). Some OTDs and their families were from culturally and linguistically diverse backgrounds, their experiences adding complexity to the picture. Gathering information from the group as a whole reveals 'historically, politically and personally situated accounts, descriptions, interpretations and representations of human lives' (Tedlock, 2000: 455) that reflect the diversity of their experiences. It is this diversity at the level of social practice that, according to Chesters et al (2001), challenges essentialist views of rural experience. Instead, it deepens understanding of issues that contribute to both the difficulties and benefits of living and working in rural locations. Whilst recognising 'the role of prior theory in framing both the context of the data and how it is analysed' (Rice & Ezzy, 2001: 191), I adopt an inductive approach that allows new insights to emerge as a result of empirical observation that can build on existing theories (Strauss & Corbin, 1994).

## **Background**

This project was carried out in a cultural setting known to the researcher which, according to Spradley (1979: 50), can make the analysis of information more difficult because much is taken for granted due to familiarity with the cultural knowledge. On the other hand, much can also be gained as a result of that familiarity. As Scholte (1972) suggests, researchers bring their own experience, cultural background, values and understandings to the fieldwork experience. Indeed, the prospects of gaining access to participants can be increased when researchers' interests and/or experiences may reflect those of participants (Shaffir & Stebbins, 1991). Danziger (1979) studied doctor/patient interactions during pregnancy and childbirth. Her identity as the daughter of an obstetrician informed her research in various ways. She was well aware of 'the firm resistance of doctors to an outside researcher' and observed the 'care

physicians take to circumscribe scrutiny' (1979: 515). She used her familiarity with medical culture to her advantage in helping to break down barriers and gain access to information by 'minimis[ing] [her] threatening outsider status' (1979: 516).

With this in mind, I used my own family background to assist the research process and build on my understanding of some of the issues faced by rural medical families. I grew up in a medical family where my father was a doctor and my mother a nurse. I have three sisters all of whom became nurses and married doctors, two of whom are GPs currently working in rural general practice. I also became a nurse and married a doctor and we were together for over 20 years before eventually separating. I lived as a rural GP's wife for many years in a small Australian town, both of us having migrated to Australia. I was able to understand aspects of medical culture by using this knowledge and experience which often helped me to gain access and engage participants in the project. I was able to build rapport and shape my questions in interviews in light of my experience which provided a deeper understanding of issues when analysing and interpreting information. Familiarity with cultural knowledge seems particularly relevant given the challenges faced by those who 'study up' by researching elite groups within Western industrialised societies, particularly when it comes to access. According to Bell (1978: 15), 'studying up' focuses on the fact that those who control society 'define who others are, the parts others play, the parts they as controllers play as well as notions about 'society' as a whole'. In other words, 'studying up' can show how hegemonic relations are constructed and reproduced. However, Nader (1972: 302) acknowledged that power elites are difficult to engage as they are 'out of reach on a number of different planes: they don't want to be studied; it is dangerous to study the powerful; they are busy people'. Aware of such potential obstacles, I drew on my own cultural knowledge as a way to gain access to participants which was generally, though not always, successful.

## **Gaining Access**

Feldman, Bell and Berger (2003) and Maginn (forthcoming) agree that gaining access is a crucial aspect of research yet analysis of the topic is relatively

absent in contemporary research methods literature. Maginn suggests that this implies gaining access is a straightforward process and not in need of investigation. Some researchers, notably Hammersley and Atkinson (1995) and Shaffir and Stebbins (1991), argue that gaining access to research sites and/or participants can be anything but straightforward. My own experience reflected the findings of Feldman et al (2003) who suggest that gaining access is an ongoing relational process where the researcher builds relationships with participants that form part of an ongoing, dynamic interaction involving negotiation and re-negotiation. For practical purposes, the authors break down the concept of gaining access into several stages that include finding informants, seeking approval to contact informants, entering the field and making initial contact, building rapport, developing and sustaining relationships and leaving the field. I loosely follow this framework to inform my own methods of entering the research site, finding informants and sustaining relationships.

Gaining access to an elite group also offers opportunities to add to 'studying up' theories by taking into account the role that GPs and their spouses play in the social organisation of rural communities. Given the difficulties previously mentioned in researching the medical profession as an elite group, I devised various strategies to encourage their participation, partly based on my knowledge and experience of that social group. I decided that presenting the project to potential participants in various stages over a few months was preferable to 'going in cold' when I arrived in the field. The rationale behind this decision was to slowly introduce GPs to the project, keep the door open and minimise the possibility of outright rejection.

### ***Finding informants***

In order to identify my potential key informants, I sought assistance from the Industry Partner, the GSDGP, involved in the funding of this research. This organisation had access to all GPs working in their Division. In 2002, seven months before I arrived to commence fieldwork, I visited their main office in Albany to meet staff and gather preliminary data about the demographic distribution of GPs living and working in the GSDGP and to discuss effective ways I could establish contact with them and their spouses/partners. I discovered

that the Division organises regular continuing medical education (CME) days as part of the professional development of GPs. I requested that I attend one of these before carrying out fieldwork to introduce my research project and meet some rural GPs. Participating in a local medical event allowed me to observe GPs who worked in the region and to establish face to face contact in the hope of engaging their interest in the project. I reasoned that, given the plethora of requests for information rural GPs receive in the mail, they were less likely to reject my request if they had already been introduced to the project and/or we had already met and discussed it.

At an ensuing CME day I was allotted ten minutes before the morning tea break to introduce myself, the project and my expectations of their involvement. I kept the presentation brief and informal and handed out a summary of my talk that provided information about the project and included my contact details. During the tea break, I followed up on the talk by approaching several GPs and chatted about where they worked, the research project and whether they would mind if I contacted them when I returned to do my fieldwork. All those with whom I talked agreed and gave me their names and contact details. One OTD talked at length about some of his and his wife's difficulties settling in and suggested I contact her too which I subsequently did. On the same evening, I attended a dinner organised by the GSDGP for GPs and their spouses. I took the opportunity to meet other GPs and to introduce myself to spouses and briefly explain my proposed research. I followed up on these contacts during the course of my fieldwork. One female GP stated at the end of our interview several months later that, had we not met and discussed the project at the CME day, she would not have been involved which validated my decision to introduce the project in stages.

Three months after I had presented the project, I was invited to attend a lunch in Albany for spouses of GPs in the GSDGP co-ordinated by the Rural Medical Family Network. This is a government funded organisation that offers social support to rural GPs and their families. About ten spouses attended and I explained the project over lunch and gave them printed information. I chatted with several, some of whom gave me their personal contact details and agreed to be interviewed at a later date. Meeting spouses in this way later proved

invaluable and I contacted all those I had met at the lunch, most of whom agreed to be interviewed.

### ***Ethical considerations***

Ethics clearance to undertake this research was granted by Edith Cowan University. Preserving the anonymity of participants has been a priority not least because researching a high profile group living and working in a rural area is challenging. While every effort was made to ensure protection of privacy of participants as far as possible, ‘watertight confidentiality’ is often ‘impossible’ as information is ‘often recognised by insiders’ (Christians, 2000: 139). I have made every effort to de-identify specific information such as names and workplaces to honour my commitment to respecting the privacy of participants. I have described locations generically by referring to them mainly as ‘rural’ in relation to GPs and their spouses. I have also used pseudonyms and, in order to reflect the diversity in responses within and between groups of doctors and their spouses, I have allocated each participant initials and a number (see Table 4). Classifications are as follows:

AMGP: Australian trained male GP

AFGP: Australian trained female GP

OMGP: overseas trained male GP

OFGP: overseas trained female GP

AMSP: Australian male spouse

AFSP: Australian female spouse

OMSP: male spouse from overseas

OFSP: female spouse from overseas.

**Table 4: Classification of GPs and spouses**

<b>GP</b>	<b>Number</b>	<b>Spouse</b>	<b>Number</b>
AMGP	1-13	AMSP	1-3
AFGP	1-5	AFSP	1-7
OMGP	1-12	OMSP	1-2
OFGP	1-2	OFSP	1-9

About two weeks before I was due to leave Perth to commence fieldwork, I mailed information to all GPs and their spouses in the Division. I had already

decided that my project would carry more weight in the eyes of GPs if it was endorsed by a medical practitioner. I contacted the Chair of the GSDGP, a local GP, whom I had met at the dinner following the CME day I attended, and asked if he would write a letter endorsing the project. He agreed, I drafted the letter on a GSDGP letterhead, emailed it to him requesting that he make any necessary changes and sign it (see Appendix 1a). I then sent that letter to GPs and spouses along with my own covering letter on the university letterhead, with my phone number and email address explaining that I would contact them in the next few weeks asking them to participate in the research (see Appendix 1b). With Danziger's (1979) experience in mind, I also enclosed in the package a revised information sheet about the project. In this I included a summary of my background and the fact that I had been married for many years to a GP and we had lived and worked in a rural area (see Appendix 1c). I also wrote two brief articles about the research project in the local GSDGP newsletter that was sent to all GPs in the region (See Appendix 2a). At the time of interview, all participants were given a consent form to sign where the right to withdraw at any time for no reason was stated (see Appendix 3). Prior to embarking on the main fieldwork in the GSDGP, I conducted a pilot study to test proposed interview questions for their effectiveness.

### ***Pilot project***

GPs and their spouses, all of whom had either lived or were living in a rural area, were chosen for the pilot project using a snowball technique that drew on existing contacts in my own network. Nine potential participants were contacted by phone, where I introduced myself, explained briefly what I wanted to discuss and asked for an appropriate time to call them to explain the project further. In the ensuing conversation, I gave a short summary of the research and invited them to participate in the project. All agreed to be involved. This number comprised four male and two female GPs including two OTDs, two female spouses and one male. A mutually convenient time and place were arranged to conduct an interview with each participant. This initial contact was followed up with a letter of introduction and information sheet about the project sent out prior to the interview.

Six participants lived in or around Perth and we met at a location of their choice, usually their home or office. One interview with a rural GP was conducted by phone and interviews with the two OTDs were held in the rural location in which they worked over 200 kilometres from Perth. After signing a consent form, all were interviewed separately except one female GP and her spouse whom I interviewed together at their request. Interviews lasted between 30 minutes and two hours and, where possible, were tape-recorded and transcribed. Given that the purpose of the pilot was to test interview questions, limited time was spent in participating in and observing the lives of GPs and their spouses.

I transcribed interviews and entered them into the qualitative analysis software analysis program, QSR N6, and coded the text for themes, ideas and patterns. Questions that elicited minimal information were either discarded or modified for future use. This process of evaluating the quality of questions in terms of the information they provided in the responses occurred as soon as possible after each interview. Questions were then rephrased if necessary, used for subsequent interviews and again re-evaluated. This process of assessment was ongoing whilst gathering data in the course of subsequent fieldwork with GPs and their spouses living and working in the GSDGP.

## **Data collection**

When I began fieldwork 60 GPs worked in the GSDGP and general practices were located in Albany, the large rural centre, medium rural centres large enough to support group practices and small rural centres offering the services of a solo GPs. Albany offered eight group practices and one solo practice. The majority of general practices outside Albany were located in areas designated as needing medical services. Six group practices were located in four medium rural centres with eight solo practices offering services in smaller, often more isolated communities. Some smaller locations were as close as 130 kilometres to Perth or Albany and others as far away as 530 kilometres. Solo GPs in small rural towns often practised out of a surgery in the main town and offered clinics at branch surgeries located elsewhere in the shire.

Forty five male and 15 female GPs worked in the Division (see Table 5). The majority of GPs interviewed were Australian trained with the largest group of non-Australian trained doctors being male GPs from South Africa.

**Table 5: Total number of GPs working in GSDGP and total number of GPs interviewed**

<b>General Practice</b>	<b>Male GPs</b>	<b>Female GPs</b>	<b>Total</b>	<b>Male GPs interviewed</b>	<b>Female GPs interviewed</b>	<b>Total</b>
<b>Large rural centre</b>	22	7	29	9	3	12
<b>Medium rural centre</b>	15	7	22	8	3	11
<b>Small rural centre (solo GP)</b>	8	1	9	8	1	9
<b>Total</b>	45	15	60	25	7	32
<b>Percentage</b>	75	25	100	55.5	46.6	53.3

Twenty five male GPs (55.5 per cent) working in the GSDGP agreed to participate, with ages ranging from early 30s to early 70s. Nine worked in practices in Albany, eight were members of group practices in medium-sized rural towns and eight were solo GPs in smaller rural centres. Most worked full-time (see Table 6):

**Table 6: Demographics of male GP participants**

<b>Age</b>	<b>Full-time work</b>	<b>Part-time work</b>	<b>Practice in large rural centre</b>	<b>Practice in medium rural centre</b>	<b>Solo practice in small rural centre</b>
<b>30s</b>	4	1	3	1	1
<b>40s</b>	6	1	1	3	3
<b>50s</b>	9	0	5	2	2
<b>60s</b>	3	0	0	2	1
<b>70s</b>	0	1	0	0	1
<b>Total</b>	22	3	9	8	8
<b>Percentage</b>	88	12	36	32	32

Twenty three male GPs (92 per cent) were married or in long term relationships and all except two had children (see Table 7):

**Table 7: Marital status of male GPs**

Age	Married or Partnered	Partnered with children	Currently divorced or widowed with children
30s	5	3	0
40s	8	8	0
50s	5	5	2
60s	4	4	0
70s	1	Not known	0
<b>Total</b>	23	20	2
<b>Percentage</b>	92	80	8

Seven of the 15 female GPs (46.6 per cent) working in the Division, agreed to be interviewed and ranged in age from early 30s to late 50s. Three worked in group practices in Albany, three in group practices in medium-sized rural centres and one worked as a solo GP in a small rural centre (see Table 8):

**Table 8: Demographics of female GP participants**

Age	Full-time work	Part-time work	Practice in large rural centre	Practice in medium rural centre	Solo practice in small rural centre	Partnered with children
30s	1	0	0	1	0	1
40s	3	1	3	0	1	3
50s	1	1	0	2	0	2
<b>Total</b>	5	2	3	3	1	6
<b>Percentage</b>	71.4	28.5	42.8	42.8	14.2	85.7

All female GPs were married or in long-term relationships. Three had adult children, three had young, or school-age children and one had no children (see Table 9):

**Table 9: Marital status of female GPs**

Age	Married or Partnered	Partnered with children	Currently divorced or widowed with children
30s	1	1	0
40s	4	3	0
50s	2	2	0
60s	0	0	0
70s	0	0	0
<b>Total</b>	7	6	0
<b>Percentage</b>	100	86	0

Overseas trained doctors were predominantly located in 10 of the 14 rural locations outside Albany (see Table 10). Fourteen OTDs comprising 12 male and two female were interviewed.

**Table 10 Location of OTD participants**

<b>General practice location</b>	<b>Male OTD</b>	<b>Female OTD</b>	<b>Total</b>
<b>Large rural</b>	0	1	1
<b>Medium rural</b>	6	1	7
<b>Small rural (solo GP)</b>	6	0	6
<b>Total</b>	12	2	14
<b>Percentage of total number of GPs</b>	16.6	13.3	23.3

The majority of this group of GPs had trained in, and originated from, South Africa followed by Britain. GPs also arrived from other countries in Africa, Europe, and Asia. One GP worked in a group practice in Albany, seven in medium-sized rural centres supporting group practices and six worked as solo GPs in small rural centres. The majority of these locations had been designated as areas of unmet need in relation to medical services. Most GPs had worked in a rural area in their country of origin or training (see Table 11):

**Table 11: Overseas trained doctors: length of time in rural general practice**

<b>OTDs in rural medical practice</b>	<b>0-12 months</b>	<b>1-2 yrs</b>	<b>2-5 yrs</b>	<b>5-15 yrs</b>	<b>Total</b>	<b>%</b>
<b>Current rural location in WA</b>	4	3	5	2	14	100
<b>Prior rural location in Australia</b>	1	0	2	0	3	21.4
<b>Prior rural location elsewhere</b>	0	0	0	6	6	42.8

Eleven overseas trained GPs lived with their spouses, two saw their families at weekends who lived elsewhere and one GP had been married and was currently single. The spouse of one GP had returned to her country of origin with their child as there were no opportunities for her to work in her chosen profession.

Twenty one out of the 23 spouses contacted agreed to participate in the research. They ranged in age from early 30s to over 50 (see Table 12):

**Table 12: Location of spouses**

<b>Spouses</b>	<b>Large rural</b>	<b>Medium rural</b>	<b>Small rural</b>
<b>Age 30-39</b>	2	2	2
<b>Age 40-49</b>	4	3	2
<b>Age 50+</b>	2	4	0
<b>Total</b>	8	9	4
<b>Percentage</b>	38	43	19

Sixteen of those interviewed were female spouses of GPs who had already agreed to participate in the research including nine spouses of OTDs. Four were spouses whom I had met at the RMFN lunch prior to commencing fieldwork and one was an independent contact. In addition, spouses/partners of five of the seven female GPs interviewed, including both female OTDs, also agreed to participate. Of the male spouses, one had recently started full-time employment in his chosen profession having previously reversed roles with his wife, one worked part-time, one operated a business from home and two were looking for paid employment. One female spouse worked full-time outside the home, five worked part-time in various occupations and ten were not in paid employment (see Table 13). The majority of spouses had been trained as professionals:

**Table 13: Spouses' employment**

<b>Spouse</b>	<b>Full-time work</b>	<b>Part-time work</b>	<b>Not employed outside the home</b>
<b>Male</b>	1	2	2
<b>Female</b>	1	5	10
<b>Total</b>	2	7	12
<b>Percentage</b>	10 (total) 20 (male) 6 (female)	33 (total) 40 (male) 31 (female)	57 (total) 40 (male) 63 (female)

GPs who were interviewed had lived and worked in rural locations for varying periods of time ranging from one week to over 30 years with one GP practising medicine in the town he grew up in. Six of the 13 Australian trained male GPs had been practising in a rural area for over 20 years and only one for less than 2 years. The majority, including OTDs who had worked in rural areas in their countries of origin, intended to stay practising in rural Australia.

### *Entering/leaving the field*

Information from the field was gathered in 2003 from a range of sources in a variety of contexts. To minimise bias and reflect the diversity of locations, I visited every general practice in the region covered by the GSDGP over a period of four months to invite GPs and their spouses to participate in the research. This involved travelling over 6000 kilometres by car to cover an area of 87 000 square kilometres. Overall, including the time taken on the pilot project, I spent more than five months in the field gathering information and beginning the analysis and interpretation of data. Living in the area for several months for the sole purpose of carrying out the research proved beneficial. It indicated to participants my commitment to remain in the area for the duration of the data gathering process, rather than make occasional visits from the city. It also offered flexibility to participants when I arranged interviews or attended social functions. At the beginning of fieldwork, making explicit my intention to remain in the area for several months to gather information also facilitated leaving the field-site once sufficient data had been gathered.

Sorting out my accommodation in the field turned out to be serendipitous in finding key informants who assisted in the process of contacting GPs. Jessica,<sup>27</sup> a friend of Lucy who worked at the Division, was someone I had never met before starting fieldwork. Lucy had initially suggested I stay with her whilst I was working in Albany but withdrew her offer at the last minute. Jessica stepped in and invited me to stay, asking me to house-sit for six weeks while she was on holiday. I agreed and Jessica subsequently became a key informant. She was familiar, with the location having lived and worked in the area for many years. She was employed in a health context and knew many of the GPs. She assisted in the process of accessing GPs by suggesting that practice managers (PM), not receptionists, were the gatekeepers. With this in mind, I decided that to be successful in meeting GPs and engaging them in the project was contingent on first building rapport with their PMs. Before Jessica left, she introduced me to one PM, Liz, who was interested in learning more about the project. Following

---

<sup>27</sup> All names of individuals are pseudonyms

our meeting, she introduced me to four GPs in the surgery in which she worked, all of whom agreed to be interviewed. I conducted my first interview that day.

However, I had enough personal experience to know that if you arrive at the surgery, are not introduced to the PM, are not a patient and expect to see the GP to arrange an interview, there is a high probability you will be rejected with the catchcry that the GP is 'far too busy' and is 'completely booked up', with not much recourse to return and try again. This reinforced my decision that building rapport with the practice manager was necessary to engage GPs in the research. In an excerpt from my field notes I made the following observations:

It seems that if I can actually get past the PM and talk, however briefly, to the GP I can usually persuade them to be interviewed. I go with whatever time the GP offers to give me for an interview. This can be five minutes which usually will extend to 20, to an hour and a half. One interview was spent travelling with a GP to the hospital, waiting in the corridor while he saw his patients in the ward, resuming the discussion while driving back in his car and then finishing off the interview while he ate his lunch in his surgery. ... The catchcry for me is 'be prepared' so I go everywhere clutching a copy of questions to ask, consent forms, a letter of endorsement from the Chair of the Division, not to mention information sheets as GPs have either forgotten what I sent or never read them or binned them. I also take a tape recorder, adapter, two cassette tapes, an extension lead and a pad and pen to take notes as a back up in case the recording fails. Just as well. I was introduced to one GP by the PM in between patients and the GP said he was free and I could interview him straight away, which I did (Excerpt from field notes July 2003).

Hammersley and Atkinson (1995) suggest that meeting and overcoming obstacles to gaining access offers the researcher insights into the social organisation of the setting. Practice managers as the gatekeepers of the GPs are the 'conduit' through which attempts to access the GP pass, so PMs are powerful. They 'protect' the doctors by filtering other people's demands on the GPs' time, including pharmaceutical representatives and researchers like myself, by prioritising their degree of importance. They attend to the smooth running of the practice on a daily basis and their responsibilities may include managing the staff, business and administrative aspects of the practice. Some also organise the GPs and humour them when necessary.

The majority of PMs were women although men held the position in the two biggest practices in town. My strategy was to arrive at the surgery, carrying my information package on the project and ask the receptionist for an appointment to see the practice manager. This was generally successful and I either saw the PM straight away or arranged an appointment. When I met him/her, I thanked them for seeing me sometimes making a positive comment about the surgery, helpful staff or even the weather to break the ice. I briefly explained who I was and what the project involved and asked for their help as to the best way to contact the GPs. I took time to build rapport, hoping they would be predisposed to presenting the project in a positive light to the GP. I discovered that, if rapport was established, PMs generally went out of their way to assist me. If not, they indicated that the GPs would not be interested in the research and signalled the end of our conversation. Sometimes, when I persisted, the PMs agreed to ask the GP though not always with successful outcomes. I ruminated on some of the reasons PMs responded differently and recorded my reflections in field notes:

The role of the practice manager as gate keeper is interesting particularly in the context of the social organisation of the practice. There is a difference in a PM being proactive and in a position to guide/advise GPs as opposed to being a glorified receptionist who lets the GP make the decisions. The key for the proactive PMs seems to be whether the PM feels the project is worthwhile and will benefit the GPs, which may influence how they present it to them. In this case, a proactive PM has more influence than a passive one who would probably respond to what the GP cues in terms of interruptions to GPs' 'real work' which is clinical practice. It also indicates the difference between a PM saying, 'let me introduce you to the GPs and you can ask them if they are interested' as they come out of their rooms, as opposed to 'I'll give the information to the GPs and call you' (Excerpt from field notes August 2003).

Contacting spouses in the hope of engaging them in the project proved more difficult than I had anticipated. My initial goal had been to send out information separately to GPs and spouses as a way to symbolise their separate identities and ensure the information reached both parties. However, I was unable to access personal addresses which were confidential and not on the Division's data base. As a result, information was addressed to both GP and spouse and

posted to the surgery address. In terms of social organisation, this gave GPs the power to act as gate-keeper and decide whether to pass on the information to their spouses. I am unsure whether all spouses received the information and none contacted me personally to ask to be involved.

An alternative approach was to ask GPs whom I interviewed for their spouse's contact details which was usually successful. However, this approach again placed the GP in the position of gate-keeper. All overseas trained GPs gave me details where I could contact their spouses, all of whom agreed to be interviewed. Most Australian trained GPs also gave me details although two GPs declined on the grounds that their partners were either not well or were very stressed. If GPs chose not to be involved in the project, then opportunities to contact their spouses were significantly reduced unless I happened to meet them in the course of fieldwork or someone, other than the GP, gave me their contact details.

Methods of gathering information included participant observation, semi-structured interviews, conversations with GPs and their spouses in social settings, informal discussions with other community members, health professionals, local government officials, and examination of archival materials such as government reports, historical documents and media articles.

### ***Participant observation***

An ethnographic approach refers to a set of methods where the researcher participates in and observes people's daily lives over an extended period of time, watching events, listening, asking questions and gathering any information that might help in understanding the focus of the research (Hammersley & Atkinson, 1995). Participant observation allows the researcher to see first-hand what occurs in a given context rather than rely on the observations of others (Altheide & Johnson, 1994). Given that, as a researcher, I might not know what information may be helpful, I accepted the parting words of a university colleague who reminded me that 'everything is data' including the rejections, the obstacles and the disappointments. While the researcher seeks to understand the participants' definition of their reality and the 'organising constructs of their world' (Burns, 1997: 310), he/she can also critically observe that reality in the light of a broader

social context. The dominant role of the GP in rural health care, reflecting their position of power in the organisation and delivery of services, is a case in point (see De Laine, 1997).

The hours spent sitting in surgeries waiting to interview GPs allowed me to observe interactions between GPs and their staff including the practice manager, the practice nurse and the receptionists that provided information about the social organisation of a rural general practice surgery. Sometimes, a GP invited me home to dinner where I noticed the setting, the interactions between family members, the division of labour and the meaning attributed by family members to the GP's work. This information offered a vignette of social organisation within a specific, non-professional context. I also participated in various social activities in different locations: attending functions at the local museum or art gallery, being invited to fund raising events or to dinner at the home of the GP and occasionally stopping to chat with GPs and their spouses at coffee shops or when walking along the beach. I struck up conversations with other local residents in various settings: wandering around local markets, attending agricultural shows and wine festivals, art gallery and museum openings or chatting to people in GPs' waiting rooms. When I explained the purpose of my research, people's responses often yielded rich information with some openly expressing their views on the role of GPs in rural health service delivery. Responses ranged from some believing GPs occupied privileged positions that subordinated those who also offered necessary services in rural locations to others believing rural GPs were close to sainthood and were entitled to whatever incentives they were offered.

Writing field notes constitutes a central focus of ethnography (Hammersley & Atkinson, 1995). As Emerson, Fretz and Shaw (1995) suggest, field notes provide documentation of observations, impressions, interpretations and experiences of people, settings and events. I also wrote down my reflections, 'ideas, fears, mistakes, confusions, breakthroughs and problems' (Spradley, 1979: 76) as a way to learn from my experiences and develop my understanding of the context in which I was working. For greater accuracy, I preferred to record my responses within 24 hours of an interaction or event while they were still fresh in my mind and I could remember details. Field notes also offered useful

descriptive information as well as important analytic leads. Recalling Emerson et al (1995), they helped identify my biases, prejudices and changing attitudes towards people and events that I experienced over time. To increase my motivation to record my field notes, I developed an enjoyable ritual following interviews with GPs and their spouses:

I have discovered all the good coffee shops in town where I go after interviews to chill out and write up my impressions, thoughts, ideas, and hunches about what happened, as well as taking in the view of the King George Sound while sipping delicious, freshly-roasted coffee. The coastline is so beautiful with views to die for from various locations in and around the town centre. Gathering information, especially organising and conducting interviews has been fun, sometimes. I have also felt challenged, despondent, excited, frustrated, rewarded and constantly on a steep learning curve. I've struggled with wondering whether I am getting the right data, enough data and finding the determination to pluck up courage to cross the threshold into yet another surgery to see if a GP is willing to participate in the project. I often feel a sense of surprise and relief when they agree to be interviewed. ...Of course there are others who are not interested and I eventually accept that. I use my contact with them or the gate keepers (PMs) to establish what worked in my interaction and what didn't. I try and use this information to inform how I approach the next surgery. Sometimes, though, insights elude me and I don't know and I assume they are just not interested and I move on (Excerpt from field notes August 2003).

### ***Interviews***

Semi-structured interviews were an important method of data collection. I tape-recorded and transcribed interviews with GPs and spouses subject to each participant's written consent. Interviews were an opportunity to gather detailed, descriptive material to contextualise participants' responses and elicit information on a range of areas. These included motivating factors influencing the decision of GPs and their spouses to live and work in a rural location such as a rural lifestyle or the opportunity to practise procedural medicine. GPs also faced challenges in the workplace as a result of health reforms, bureaucratic requirements in clinical practice and their professional relationship with others working in the health field. Spouses were often met with limited opportunities to find employment or engage in further education or training in a rural setting.

GPs and their spouses occupy positions of status and privilege in the social organisation of rural communities. GPs are powerful in that people seek their expert knowledge and skills and generally listen to their advice. Building rapport at the beginning of the interview and sustaining it throughout, particularly when interviewing members of a powerful social group, was something I considered essential to creating an environment for effective communication (see Encel, 1978; Feldman et al., 2003; Hammersley & Atkinson, 1995). With this in mind, I conducted the interview process whilst at the same time building rapport. I assured confidentiality in presenting the findings by reiterating that identifying factors such as names and specific locations of practice would be removed. I stated clearly the purpose of the interview was to discover and seek to understand participants' expectations and experiences of rural general practice while at the same time building rapport by being respectful, listening attentively and occasionally paraphrasing their responses to ensure I had understood the meaning. I noticed participants' non-verbal responses to questions that helped influence the direction of the interview. This approach allowed me to engage with participants by being sensitive to, and interested in, their responses and build an atmosphere of trust where they were encouraged to talk, reflect, discuss and explore the issue being addressed.

I had modified and developed questions in interviews with GPs and their spouses involved in the pilot project and used the revised version in interviews in the main project. Initial questions were designed to decrease any anxiety and create a relaxed atmosphere where participants felt comfortable. Questions in the body of the interview were open-ended and phrased to elicit as much relevant information as possible about factors affecting their lives and work practices in a rural location. A demographic profile of each participant was taken during the interview for future analysis to note similarities and differences between GPs and their spouses and the locations in which they lived and worked. I often referred to the set of prepared questions during the interview which assuaged my anxiety and gave me some control to guide the discussion in specific directions. However, not all questions on the interview schedule were asked in every interview. Time constraints and/or participants' responses that engaged more deeply with certain topics that warranted further reflection prevented this. As

rapport and trust developed, particularly with those interviewed more than once, communication became less guarded as participants expressed more openly their difficulties and challenges in a professional and personal context that allowed a deeper exploration of the complexity and nature of meanings and interpretations they attributed to events, expectations and experiences. I referred less to the prepared questions on occasions like these to give participants the opportunity to reflect more deeply on their experiences. As one GP commented, he had only ever previously discussed with his wife the price they had paid as a family for the demands placed on his role as a rural GP when it intersected with his role as a husband and father and on his own mental and emotional wellbeing.

General topics covered in the interviews included GPs' and spouses' expectations and experiences of rural general practice and its interface with the demands of home. More specifically questions for GPs revolved around the impact of recent health reforms on how rural GPs practise medicine including issues related to medical accountability and the threat of litigation. Other topics related to the increasing feminisation of the medical workforce, changing patient requirements, participants' level of involvement in community activities, links between GPs' work satisfaction and requirements for their leisure pursuits and their family's wellbeing, suggestions for innovative solutions for the future of rural health services and coping with personal and professional isolation. Questions for spouses covered their experiences as the spouse of a rural GP, their expectations of that role and their personal aspirations. For OTDs and their spouses, factors explored in interview questions included reasons they left their country of origin, cross-cultural challenges, expectations of life in rural Western Australia and social and professional support.

Interviews were conducted with 32 GPs and 21 spouses. Seven GPs and five spouses were interviewed more than once with one GP agreeing to a second and third interview. Interviews lasted from 20 minutes to three hours and were conducted at a time and place convenient for the participant. Interviews with GPs were often held at the surgery in their lunch breaks, in between patients or at home after the surgery had finished. Five were conducted in a cafe over lunch or coffee and cakes. Spouses' interviews were mainly held in their homes although they, too, occurred in cafes and two were conducted walking along the beach and

in the bush. Most were carried out separately with each participant unless they requested interviews together. The rationale behind conducting interviews separately was twofold. First, given the demands made on rural GPs, separate interviews offered more flexibility to arrange mutually convenient times and locations to meet either the GP or the spouse. Second, separate interviews also provided a context where any differences in experience, perception or expectations between a GP and spouse could be freely aired without being influenced by the response of the other. Those who requested interviews together included two GPs from the same practice, two GPs and their spouses, two female spouses and two female GPs.

### ***Informal discussions***

In order to situate the research in a broader context, I also held informal discussions with various community members including other health professionals and local government officials on their views on attracting and retaining more GPs as a way to solve the rural health problem. These included discussions with six HSM/DONs in different locations and six CEOs of rural shire councils. Sometimes we met socially or I contacted them directly by visiting their place of work and making an appointment to see them to explain my research and discuss their ideas about the role of GPs in rural health care. I was also interested in their thoughts about innovative solutions to the problem. These discussions were not tape-recorded though I generally made notes during or after the conversation.

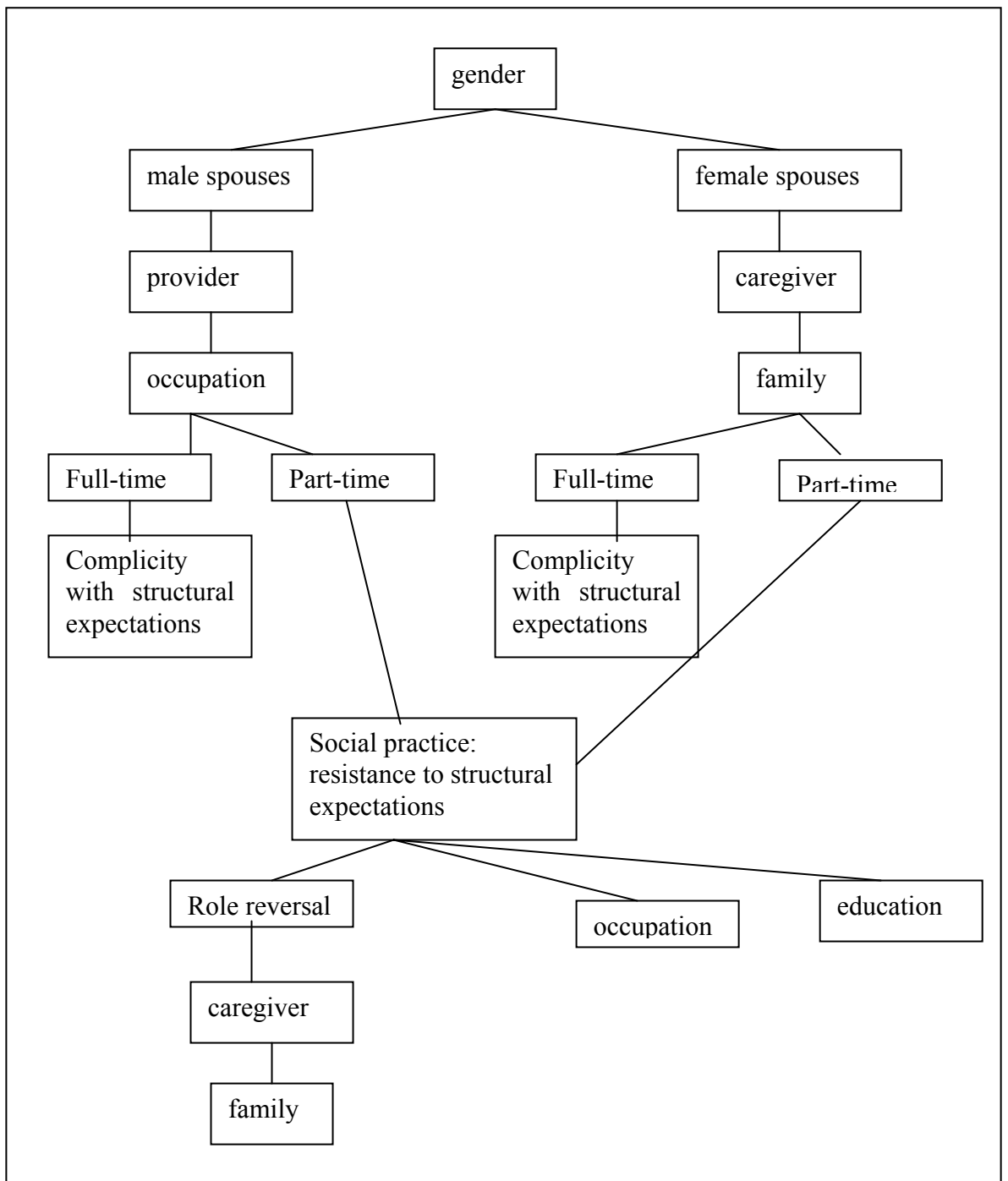
Discussions were also held with GPs and their spouses if we met socially. These were generally relaxed and informal though participants often brought the conversation around to discussing the research and made comments on their experiences and challenges. This was the case following an invitation to dinner from one OTD which was also attended by other friends of the GP and led to a discussion on challenges facing OTDs and their families living in rural locations. Some of the issues aired in discussions with participants and various community members were substantiated in archival material reporting on the state of the rural health service and the shortage of rural doctors.

### ***Archival material***

I searched various documents including oral histories of GPs who had worked in rural practice, historical records of various local settings I was visiting, media articles on rural general practice, government reports and local policy documents to help contextualise the research and supplement other information I was gathering. This information was accessed from rural shire council offices, local government departments, rural hospitals, local libraries, tourist offices and the internet. Some of these locations provided opportunities to meet people and discuss their thoughts and ideas about rural health and medical services. Newspaper articles were sourced from national and state daily newspapers and local community newspapers and newsletters.

### **Data analysis**

Information was analysed and interpreted in four stages. First I drew on Wolcott's ideas (2001) to describe the setting, events and key players involved in the project to provide a firm foundation on which to build the study. This became the backdrop against which ongoing analysis and interpretation evolved. Second, a preliminary analysis was conducted to reduce, organise and interpret raw data such as transcriptions, notes from interviews and field notes (Sarantakos, 1998). Transcriptions were imported into the qualitative analysis software package, QSR N6 which was used to collate and manage the data. Adopting an inductive approach, information was coded and categorised by sorting it into themes, ideas, concepts, hunches and patterns (see Strauss & Corbin, 1994; Wolcott, 2001) which were revised, modified, developed and refined as part of the ongoing analysis process. An index tree was used as a model in the N6 program to analyse, code and store data. Figure 1 gives a basic outline of the process showing the top level or dominant tree node representing a main theme under which are placed related themes or ideas coded from the data that are stored in various levels of sub-nodes from which emerge other sub nodes related to the dominant theme.



**Figure 1: Index tree: model of analysing and coding raw data into themes using Qualitative Solutions and Research (QSR) version N6**

For example, gender as an overarching theme might be organised into sub-themes such as the role of spouses of rural GPs who conform to structural expectations of gender relations with male as provider and female as primary caregiver. Another sub theme may represent resistance such expectations. This model illustrates how the analysis process develops and deepens. Specific themes or concepts are not mutually exclusive and may overlap with other themes. The work practices of female GPs may overlap with the division of labour in the home in rural medical marriages that could warrant a deeper enquiry into expectations of gender roles.

Themes, ideas and concepts were regularly reviewed, modified, developed, refined and summarised. Patterns in responses within and between groups, individuals and settings were identified and analysed for similarities and differences in the light of research questions. Conclusions began to form about how knowledge is constructed and shared, how power is organised. Understanding also developed of cultural meanings participants and different groups within the community attributed to the expectations and experiences of GPs and their spouses in rural locations. This iterative approach generates further questions to deepen the enquiry and seeks to understand and clarify deeper meanings that emerge from the analysis.

### ***Interpretation***

Third, echoing Wolcott (2001), the researcher's past experience, intuition and understanding help in interpreting the data. In other words, I used my cultural knowledge and experience of the lives of rural GPs and their spouses, and my sociological and anthropological background, to interrogate the information I had gathered in the field and set it against a backdrop of the research questions underpinning the project. This process allowed the data to be viewed from different perspectives so new meanings could emerge and lead to a deeper understanding of the relationship between structure and social practice. Theoretical perspectives also guided interpretation and further deepened my understanding of the data. Sorting, analysing and interpreting information effectively began on entering the field. I used field notes to record my thoughts, ideas, reflections, hunches, surprises and disappointments in response to events,

locations and interactions with participants and residents in different rural centres. This process provided early identification of emerging themes and patterns that were subsequently expanded, corrected, modified, summarised, and constantly revised as part of an iterative process.

Fourth, I critically analysed the ‘insider’s view’ (De Laine, 1997: 124) to more deeply examine the role of structural issues in social practice. Specific events and interactions within and between groups of participants were located in a wider social setting. This allowed the relationship between structural forces and social practice to emerge that revealed the organisation of power relations in a rural general practice context. This widened the lens with which to analyse the expectations and experiences of GPs and their spouses in the context of rural health service provision. Data could then be interpreted with a view to examining the dialectical relationship between broader structural issues and their impact on social practice. Drawing out ‘cultural assumptions in which biomedicine is grounded and the practices that sustain it’ (Lupton, 2000: 12), offered a deeper analysis of factors reproducing and contesting relationships of power. Tension experienced at the level of practice in the face of structural changes may reveal a struggle that can be examined more deeply for its potential to offer alternative solutions to the problem.

### ***Rigour***

Quantitative researchers expect reliability in findings if they are repeated by themselves or other researchers. This is not always possible in qualitative research. Studies of a particular group by one researcher in the field cannot necessarily be replicated as events that occurred in a natural setting at a specific time and the dynamics of relationships between participants and researcher cannot be reproduced (Burns, 1997). However, qualitative researchers see one aspect of reliability as recording data to reflect what actually happened in the field, enhanced by careful description and explanation of ‘physical, social and interpersonal contexts within which data are gathered’ (Burns, 1997: 323). A key component of ethnography is to see first-hand what occurs in a given context rather than asking others for, or relying on, their recollections or observations or interpretations (Altheide & Johnson, 1994). While we cannot assume the truth of

what participants tell us beyond reasonable doubt, dismissing their descriptions of thoughts, feelings and actions as having no face value is unwarranted (Hammersley & Atkinson, 1995). Ethnography rests on accurately representing as far as possible particular social phenomena that are revealed in participants' responses, actions and behaviour. This process assists in interpreting their meaning and function (see Atkinson & Hammersley, 1994; Hammersley, 1992). According to Altheide & Johnson (1994) methodological rigour is demonstrated through describing how the researcher presented herself to participants, gained access to organisations and individuals, built rapport and developed trust, responded to mistakes and surprises, and collected, recorded and interpreted information. I have attempted to meet these requirements when approaching this project.

## **Limitations**

Information gathered from GPs and their spouses for this project is localised to a specific rural area and does not offer a comparative analysis with GPs and spouses in other rural areas or metropolitan centres. A study of the clinical aspects of the doctor/patient encounter has not been researched.

The next four chapters will present the findings from information gathered for this ethnographic research project. Chapter 5 focuses specifically on the expectations and experiences of GPs trained in Australia.

## **CHAPTER 5**

### **Facing changes to work practices: expectations and experiences of Australian trained male rural GPs**

The hegemonic position GPs hold in the hierarchy of rural health professionals is symbolised by their autonomy, power and control over their work practices and those of other health professionals (Germov, 2003a). GPs' privileged status is also reflected in the esteem in which they are held in rural communities. However, social changes have caused tension in the relationship between rural GPs and the State as GPs cope with the effects of political and economic reform and changes in gender relations as increasing numbers of women enter the medical workforce. As rural GPs adjust to such changes, the question asked is whether their dominant position in rural health care delivery is being destabilised by events beyond their control? Currently, all rural GPs are faced with the significant role played by market forces in health care delivery. Cost cutting, increased government surveillance in clinical practice, calls for accountability from consumers and threats of medical litigation are common concerns in everyday practice often affecting work enjoyment. Studies show that many rural GPs in Australia are unhappy that governments are encroaching on their autonomy and control in the workplace and imposing increasing regulations that demand more accountability for their actions (Strasser et al., 1997; Wainer, 2002). Added to this, competition from other health professions to provide services is on the rise, larger corporations are buying medical practices, and growing numbers of women entering the profession are demanding a more flexible approach to working hours. In this climate, the ethos of rural general practice is changing; it is currently in a state of transition with many GPs feeling frustrated and uncertain about the future.

Despite these developments, many Australian trained, male rural GPs interviewed for this study continue to enjoy their work and plan to stay in a rural area. One reason for their choice is the opportunity to practise a variety of medical and procedural skills not available to most urban GPs. Findings also

reveal the hegemonic role played by the State in clinical practice. The State provides the economic framework in which health services operate. Health reforms and calls for greater accountability in clinical practice, such as encouraging GPs to practise evidence based medicine and become vocationally registered, have met with a mixed reaction. Evidence based medicine requires GPs use the best external clinical evidence currently available in conjunction with their own clinical knowledge and skills to make decisions about patient care (Australian Government Department of Health and Ageing, 2005: 593). GPs are required to undergo vocational training to provide them with necessary skills and knowledge to practise competently in the community. Vocationally registered GPs have been admitted to Fellowship of the Royal Australian College of General Practitioners (RACGP), which entitles them to access higher Medicare payments from the Health Insurance Commission for providing services. GPs are required to maintain their vocational registration through ongoing professional development in accordance with the Quality Assurance and Continuing Professional Development Program run by the RACGP (Australian Government Department of Health and Ageing, 2005: 604). Despite the benefits offered, not all GPs choose to become vocationally registered. Stated reasons for this include impending retirement or the fact that they are overseas trained and working on temporary resident visas in areas designated as needing medical services (Australian Government Department of Health and Ageing, 2005).

In response to increasing government intervention in clinical practice some rural GPs feel angry and uncertain about the future despite offers of financial remuneration as an incentive to adopt reforms. GPs who implement government regulations that expect more accountability from doctors provide a way for governments to place their clinical practice under scrutiny. Such reforms effectively reduce rural GPs' control over their work practices. The dialectical relationship between the State and the medical profession in a rural general practice setting is revealed in some Australian trained male GPs' angry responses to such structural constraints. However, others in this group view such reforms as inevitable in the current political and economic climate, believing that there is no alternative. They consider that, by working with the changes rather than against them, they and the general practice in which they work could benefit financially.

Despite the reforms, many male rural GPs continue to work long hours although the image of the heroic, rural male GP is coming under pressure.

A dialectical relationship between structure and social practice is also revealed in the context of gender relations in rural general practice. Some Australian trained male rural GPs are becoming increasingly reflective and are resisting this 'heroic' image in the face of social changes. They are proactively initiating changes to work practices by reducing their hours in order to achieve a better balance between work and home. This shift supports Pringle's (1998) idea that a major change in work ethic is already happening in medical work settings. Research from Britain suggests a ripple effect is occurring where growing numbers of male GPs of all ages are resisting conventional stereotypes of long working hours, instead seeking a lifestyle that is more balanced with room for greater flexibility in work arrangements (Young et al., 2001). However not all rural GPs are so receptive. Tension is evident in some rural male GPs' responses as their female colleagues adopt a different approach to work practices from the 'norm'.

This chapter identifies the dialectical relationship between structure and social practice by examining the expectations and experiences of Australian trained, rural, male GPs in the face of changes to gender relations and the political and economic climate. First, it identifies their responses to growing numbers of women entering the medical workforce. It then examines the effect of political and economic changes at the level of social practice. Australian trained male rural GPs discuss how they manage the tension in the face of structural requirements that often cause stress in the workplace and in the home. This perspective offers a more nuanced analysis of issues influencing the decisions of GPs to stay living and working in a rural location.

### **Feminisation of the medical workforce**

Drawing on ethnographic findings, responses indicated that female medical practitioners sought to balance work and family time. The majority of Australian trained, male rural GPs who worked long hours held conventional views of the division of labour and assumed women GPs would adopt the role of main caregiver in the home:

A few female GPs are full-time but they make a certain sacrifice to do that by not having children. It is children who really create the problem for female doctors. So for every child [a female GP has] there is a good 18 months [off work]. It is difficult to work when the child is little and some of them will drift off and come back later. You could lose them for years depending on what their values are and what they think is important (AMGP6).

There is an implicit assumption in this response that it is the woman who is the primary caregiver. Most male and female GPs are married or in committed relationships (Lippert & Tolhurst, 2001; Pringle, 1998). Male rural GPs often argued that the nature of rural general practice involved long working hours even though some of their male colleagues chose to work less to achieve a more balanced lifestyle. Their expectations that female rural GPs conform to conventional work practices and take responsibility for childcare and domestic tasks in locations with limited childcare services are not sustainable. Women who worked fewer hours effectively challenged the heroic approach to rural general practice. Nonetheless, hegemonic ideas of work practices were reproduced as male rural GPs were often concerned that their female colleagues ‘would not want to work as hard as we do’ (AMGP1) which would ‘significantly impact’ (AMGP5) on how rural medicine is practised. One GP commented wryly that the brunt of the workload would fall to male GPs when female GPs went home:

So the government will flog the ten male doctors to death quite happily. So will the other women (AMGP5).

In this instance, female GPs were held responsible for increasing the workload of their male colleagues, rather than the organisational structure of rural general practice that makes it difficult for women to meet the demands of home and work.

While different approaches to work practices caused tension in the ranks, other Australian trained male GPs supported the trend towards working fewer hours. One GP suggested that such a move was conducive to ‘self preservation’ where anti-social hours were no longer tolerated. He commented that there had been a ‘cultural shift’ in rural general practice where ‘there is a lot more

awareness about what is necessary to function well, and a lot more political lobbying' (AMGP12). Another GP agreed, commenting that:

Younger doctors are saying they want a life beyond medicine which is what I was saying 20 years ago and I was told to get lost. It didn't happen (AMGP10).

One older GP, reflecting on younger male GPs supporting such changes to work practices, mused:

They have probably got their priorities right. It depends on what your ambition is. My ambition was to build up a capital base for retirement because I had never had any money so there was an inclination to work harder and then send children away to boarding school and work even harder (AMGP6).

Nonetheless, for flexible working hours to become the norm, reassessing the organisational structure of rural general practice is necessary and rural GPs who chose to work less would have to be prepared to take a cut in their salary:

One of the crucial differences I have noticed in young doctors ... is that they have been told by the college how much they work so they all feel very 'precious'. They need to realise that if they don't work they are not going to get the money. The problem arises when they don't want to work but still want the same amount of money. That becomes a real problem (AMGP1).

The variety of responses suggests that tension exists amongst some male rural GPs in the face of structural requirements which they feel conflict with their interests and ideas about rural general practice. In other words, the dialectical relationship between structure and social practice is evident as some GPs struggle to reproduce hegemonic ideas of rural general practice in the face of increasing numbers of women in the medical workforce. Tension is evident as many women GPs contest dominant ideas about rural general practice and open the door to allow new ideas and work practices to emerge. As a result change is occurring with some male GPs supporting the changes. In this light, appropriate workforce planning becomes an important issue to ensure adequate health services are provided in rural locations. Other structural factors are also affecting the expectations and experiences of Australian trained, rural male GPs.

## Effects of health reforms on rural GPs' work practices

### *The bureaucratic gaze*

Increasing government control in clinical practice is undermining the power and autonomy of the medical profession. Power has shifted away from the doctors exercising authority over their work practices and towards government support of neoliberalist principles governing health policy. This has resulted in, among other things, calls for the medical profession to be more accountable for its practices. The dialectical relationship between structural changes and social practice is evident in the frustration many rural GPs feel at the State's unwelcome intrusion into what they consider as their territory. According to one GP, the fear of change has led GPs to 'drag each other kicking and screaming into the 21st century' (AMGP1). GPs reflect the tension in their relationship with the State, with some GPs commenting explicitly that their autonomy and control is being undermined:

Government control is definitely affecting GP autonomy. ... There is increasing government encroachment and it seems uncertain as to what it is they exactly want. It all revolves around money, not health care. They don't really care about the health of the people I see. That is the impression. They are more worried about the money (AMGP5).

Other responses suggest that government control is weakening the institutional power of the medical profession through constraints on clinical practice under the banner of maintaining standards and quality control in service delivery:

I don't have a problem with quality control. It is important to have quality assurance and quality control. ... Every doctor needs to ... spend significant time updating their knowledge and skill. ... My perception, probably shared by many of my colleagues, is that other parts of [government] regulation are red tape that give the government more control over the system. ... The trend is towards tighter government control. Some of the things we have been seeing in the Medicare system are that things are getting more regulated rather than less regulated. My suspicion of this is the government agenda of cost containment which is their high priority (AMGP2).

Indeed, implementing reforms involving increased accountability from the medical profession has often met with opposition. White (2000a: 292) argues

that many GPs resisted the introduction of vocational registration which was seen as a method of government surveillance of medical work practices that undermined doctors' control. Nonetheless, the State retained its control and gained the consent of GPs to such reforms by instituting penalties for non-compliance that deprived GPs of financial rewards. Financial incentives, such as PIP payments, are offered as a motivating factor to comply with health reforms, with negative consequences for non-compliance:

Accreditation [of a general practice] is tied in now to the remuneration package. If you are not accredited there are certain parts of the Medicare benefits which you can't access ... So again this is an area where further control has come in. I think accreditation is a good thing. I am all for quality assurance activities...But again the government has managed to [exercise its control] where there is a financial penalty if you don't comply (AMGP2).

GPs who are not vocationally registered are prevented from claiming a higher scheduled fee from Medicare for their services. Currently 77.7 per cent of GPs throughout Australia working full-time are vocationally registered, most of whom practise in metropolitan centres (Australian Government Department of Health and Ageing, 2005: 103, 115).

The interface between neoliberalist principles and clinical practice has caused disquiet:

The concerns of the marketplace are invading doctors' work to the extent that it does affect how they handle their patients. They over-service their patients in order to increase their income and write repeat prescriptions so the patient has to come back. Bad medicine but good business. ... There should not be a business side. We should be insulated from the concerns of the marketplace. ...The concerns of the marketplace should not intrude on our motives [for practising medicine] (AMGP9).

Another GP also reflected his anxiety in this context commenting that 'GPs don't get any training at all in the business side of running a practice' (AMGP6). His response is not unique given that some of the larger general practices now employ a business manager, a service often not economically feasible for smaller practices.

Responses from many male GPs expressed that increased government intervention had diminished their enjoyment of general practice, not least because they felt coerced into meeting bureaucratic regulations:

There are so many requirements that you can't just treat diabetes. You have to do a diabetes care plan whether people want it or not. You don't really have to, I suppose, but then they won't pay you. There is control and manipulation (AMGP5).

Some were outraged at the reforms, with one solo GP saying that government control 'decimated my enjoyment of general practice and my pride' (AMGP11), while others just felt disillusioned at their loss of autonomy in clinical practice (AMGP5, AMGP4, AMGP11). They felt disempowered and frustrated as they sought to meet government regulations and submit claims to access financial incentives. This process generally incurred extra time and costs over and above their clinical work that were not remunerated:

It takes hours to work out what you can claim ... within the HIC system. We are actually having to pay people to get all the bureaucracy under control (AMGP6).

Tension in the relationship between the State and rural GP is evident in the sense of irritation GPs feel as the administrative burden of many work practices has increased to comply with government regulations:

The big complaint is that people spend so much time proving they are [practising good medicine] that they don't have time to [practise] it because so much time is taken up in the paperwork. ... It is frustrating and irritating because it is time away from doing what you want to do which is clinical work (AMGP9).

The dialectical relationship between structure and social practice is evident in those GPs who withstood the tension and chose to accept government health reforms. They made the decision to work with, rather than against structural elements by adapting to the current political and economic climate in a way that best served their interests and those of the general practice in which they worked. There was a sense that resisting government reforms was pointless and counter-productive:

Our experience is that resisting change is futile because there is someone very high up in Canberra and the State Health Department who has a plan and they will implement that plan because, at the end of it all, they believe they will control the health budget. Because of the futility of resisting, we think it is better to implement the system if you think it is worthwhile. ... One of the things we believe is that, unless you stay close to the government, you have no idea what is going to happen. If you stand and stone wall, it is not going to change the government unless you are a particularly powerful lobby group and GPs aren't because they have multiple representatives and no two GPs will agree on anything much (AMGP6).

This response illustrated the hegemonic position of the State and was supported by comments such as 'there is no point resisting them' (AMGP7) although this GP conceded that:

Once we move into total bulk billing and PIP (Practice Incentives Program) payments and whatever else you can get hold of, you may as well be working for the government. You have lost your autonomy. This is what the government wants us to do (AMGP7).

These comments suggest a gradual, but systematic, erosion by the State of the traditional power base of the medical profession that is undermining doctors' control over their work practices. Nonetheless, demands for accountability were not considered unreasonable in that people have a right to expect quality of care. One GP thought more research was necessary on the link between cost and health outcomes:

I don't have a problem with accreditation and ongoing CME but I think there needs to be a careful balance. There is a danger as the government is quite quick to link those positive reforms to regulations and cost containment. In their defence, they say, 'we are spending all this money, what are we getting for this money?' There hasn't been good data about outcomes; even now that all this money [has been spent] on doctors and GPs, does it actually improve the health of Australians? [The government] is on an agenda to at least get evidence, 'best practice' that [they] are spending all this dough and want to actually see that it makes a difference. I think that is reasonable (AMGP2).

Such comments reveal that the interests of the medical profession and the State may conflict, yet the tension generated as a result of this struggle has the

potential to lead to change. At one level the comments illustrate how the State creates a consensus around the centrality of a neoliberalist agenda in government health reforms where health outcomes are achieved by cost effective practices. Such reforms calling for accountability may indeed diminish the autonomy and control of rural GPs over their work environment and highlight the hegemonic position of the State in its relationship with the medical profession. However, the above GP also reflects on the need for accountability within the medical profession to ensure, not only value for money, but also the motivation to provide quality care for patients. Other reforms were also affecting the social practice of rural GPs.

### ***Competition***

Neoliberalist principles underpinning health reforms that encourage competition for services have also affected GPs, their fee structure and negotiation of work contracts with local hospitals. Competition is another ‘site’ where the hegemonic power of the State influences the terms and conditions of rural GPs’ work practices:

The government has been pushing competition. We have an ACCC (Australian Competition and Consumer Commission) which safeguards competition. Doctors have been on the receiving end and have to be very careful about the fees they set. ... Until recently the ACCC said you shall not set a fee across a surgery. Every doctor must set their own fee. If you do [set a standard fee] that is deemed as colluding and engaging in anti-competitive behaviour (AMGP2).

The same GP expanded on this theme in the context of work contracts between rural GPs and the local hospital:

[The local hospital] finally got its act into gear. When it came to signing, we had the right to negotiate the contract as individuals but not as a group because the ACCC would come down on us. So we don’t really have a lot of power in this respect. ... We were forced to sign [the contract] because we weren’t in a position of power to negotiate [as a group]. If I say ‘I’ll pull out, I am not interested in this contract’, the hospital still had all the other GPs. ... There is competition but it was an example of the way those competition laws worked in favour of the government (AMGP2).

Whilst the relationship between the GP and hospital management was sometimes conflictual, it was often expressed as a clash of personalities. In reality, the relational conflict illustrated the interests of different institutions and suggests a clash of 'systems' within the organisational structure of health service delivery. The hospital as an institution of the state of Western Australia is required to operate within budget constraints and gain maximum efficiency and cost containment in service delivery while providing 'best practice'. The rural GP as private practitioner, whilst being required to provide quality care for patients may be restricted by limited resources at a state level. The GP also wants control over his/her work practices and the opportunity to maximise income potential with minimal bureaucratic interference.

Increasing competition for services from non-medical health professionals is also challenging the hegemonic status of the medical profession in rural health care delivery. Registered nurses and Aboriginal health workers offer a restricted range of health care services in some rural centres which, in a metropolitan centre, would be provided by GPs (Strong et al., 1998). The issue of whether all rural locations need a GP received short shrift in some GPs' responses. Instead a one-size fits all approach prevailed:

Why shouldn't [rural locations] have [a GP]? It's about equal access. Why should a community not be entitled to a doctor? The government talks about equal access to everything but it is lip service only (AMGP10).

This view clearly reflects the hegemony of the medical practitioners in relation to other health professionals who were often seen as second best. One older GP supported this view by diminishing the skills and knowledge base of nurses, claiming that 'outside of stitching a few little cuts, they have no medical knowledge' (AMGP11) with some 'rare exceptions'. He went on to argue that:

They are trained well as nurses. ... If they are going to do the work of doctors they need to be trained as doctors. ... Nurses can dish out [advice for] simple little coughs and colds and then send [patients] to see a doctor (AMGP11).

However, other GPs were willing to extend the rural health care debate beyond a medico-centric focus by consenting to nurse practitioners providing

services in localities unable to attract a GP. When asked whether there were other areas in medical practice where role sharing could occur one GP commented:

Nurses are the unsung heroes. ... [Role sharing] has got its place, for sure. It is important not to have a doctor-centric focus. The good doctor doesn't necessarily know it all. ... The skills nurses contribute to practice in remote areas are just as valuable as those brought to those areas by doctors. If you start filling remote areas with clinical nurse practitioners and consultants as a strategy in lieu of doctors, well, if that has to be done, it has to be done. It is better to have nursing staff who are well equipped and well skilled than no-one at all (AMGP12).

According to another GP, the idea of role sharing with other health professionals was 'inevitable' (AMGP4) in rural centres unable to attract GPs as long as there was adequate medical back-up. His acceptance was conditional, however, on nurses not taking away the work of doctors, again reinforcing the hegemonic role of the medical profession in health service delivery. One GP, while supporting the idea of role sharing, thought that problems of adequate staffing and cost containment would still persist:

What I see a nurse practitioner doing is living in the community and offering a service. But they are going to run into the same problem as the GP. Are they going to be available 24/7? What about back-up? It is just an extension of the same problem. They are not going to be cheap to employ, not much different from a doctor because of the hours they work and everything else. You could argue that they might have less skills than a GP. But it depends on what the GP has done. They might have just sat in a chair and consulted. And a nurse is quite capable of doing that (AMGP6).

Another GP commented that governments 'will never solve the problem' of recruiting GPs to work in smaller rural centres because GPs 'don't have any freedom' and are 'forever on-call' (AMGP7). The same GP mused on the difficulties of professional and social boundaries being blurred as:

...friendships and [work] get blended in a rural community. You would never be able to relax and put your feet up and have a few beers...The only solution is to have a nurse practitioner (AMGP7).

While some GPs vehemently resist challenges to the dominance of the doctor's role in health services, others are open to change and considering the role of nurse practitioners as a possibility. However, most considered using nurse practitioners only in areas unable to attract a GP. One issue for whoever provides health services in a rural setting is indemnity as the prevailing social climate becomes more litigious. With the medical profession being held increasingly accountable for its actions, threats of litigation in relation to medical mal-practice are on the rise.

### ***Indemnity***

The issue of indemnity in relation to clinical practice was of particular concern to some procedural rural GPs:

What worries us is where do we stop having to worry about the stuff we have done in the past? If you are working somewhere, your liability stops at the time you are working in that place. Our liability goes on for 25 years after we have delivered the last baby. So, if they are going to start having a go at me, I need to be in reasonable nick otherwise I will be in my 80s. I need to keep paying [medical] insurance policies for the next 25 years in case [I] get sued (AMGP7).

Some rural GPs had stopped doing procedural work in the area of surgery and obstetrics to offset the costs of medical insurance and minimise the threat of being sued. Others lived with the threat and remained passionate about the satisfaction they gained from the procedural aspect of rural general practice. One GP commented that he 'enjoyed every day in rural general practice' and to give up procedural work and 'just be a GP, would kill me' (AMGP7). Another said if he reached the stage when he was 'just pen pushing,' he would 'stop general practice altogether' (AMGP1). Many commented on their sense of pride in being a rural GP and delivering a good service to their patients from which they derived enormous satisfaction:

I think I can provide a very good service. I can help people. I am very happy I can do that. I am sure my patients are very happy I can do that also (AMGP1).

While quality of care was an issue for all doctors, rural GPs expressed their concern at how medico-legal issues affected their work practice at an

individual level. The threat of litigation was stressful and often led many GPs to practise 'defensive medicine' (AMGP4). One GP, with two cases pending of threats to sue him, commented that, while he ordered more investigations when diagnosing and treating a patient to legally protect himself, the risk of being sued was still a 'stress' (AMGP8). Another GP revealed the effects on his work practice of the developing trend in medical litigation:

I would only do something if I felt I could competently do it. ... I'm a bit more concerned if a claim ever comes up against me because I don't feel anywhere near as secure as I did before because I now have a very dodgy agreement with the state government, ... and I have an insurance policy which is only good for one year, to be renewed every year. So my security is much less than it was. ... I feel less secure about my indemnity to the point where I have to consider who owns what in my family because of the way the law works. It comes at you from all angles, and, if you work for so and so, they will probably sue them as well. It is quite tedious, very complex and way beyond us (AMGP6).

The sense of insecurity generated by medico-legal issues that pervade rural general practice raises the question of how rural GPs cope with the stress of work. Research findings show that chronic occupational stress is 'likely to reduce the quality of life and increase risks of negative health and mental health outcomes' (Winefield, 2003: 198). How does this group of rural GPs deal with the stress of structural reforms impacting on work practices in a rural setting?

### **Collegial support for rural GPs**

Responses suggest that rural GPs do not feel supported by their urban colleagues who 'would have no idea of the conditions we work under' (AMGP5). Instead, a disunity within the medical profession is evident where disparate groups, such as specialists, were seen to look after their own needs rather than support other medical colleagues including GPs. One rural GP suggested that different specialist groups were unified and powerful which contributed to their success in negotiating with government to meet the terms and conditions of their work (AMGP2). He commented that, as a group, GPs were 'notoriously individualistic' and divided which diminished their negotiating power politically. Another suggested that 23 000 GPs in Australia should

constitute a political force (AMGP5) particularly as several felt their grievances were not adequately represented. One GP added, somewhat despondently, that 'no one listens to GPs. We just have no say. There is nothing we can do' (AMGP3).

The division within the profession is mirrored in the various organisations representing the interests of rural GPs including the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA), the Rural Doctors Association of Australia (RDAA), the Australian Centre for Rural and Remote Medicine (ACRRM), all of whom 'vie for legitimacy' (AMGP2) and offer a 'fractured representation' (AMGP2) with each organisation meeting their own agenda. This often left rural GPs feeling their concerns were inadequately supported. One GP resolved this issue by leaving the AMA who were 'no bloody help at all' (AMGP7). The only place he felt his concerns were heard was at work. Medical colleagues in his practice offered him support and understanding. Such a response is particularly welcome in light of the lack of support experienced by many rural GPs from larger medical organisations. Such support is timely when rural GPs are coming to terms with political and economic reforms that are undermining their sense of autonomy and control over their work and affecting their enjoyment of clinical practice. This is on top of a job requiring a level of responsibility that some already find stressful.

### **Stress and rural medical culture**

Some GPs commented on the stress of responsibility that accompanies their hegemonic position in relation to other health professionals in the delivery of rural services:

We are taught that the buck stops with us. We are not team players at all. ... It is up to you. You have to act. ... You don't need to debrief. You are taking responsibility. You are going to get the kudos, you're going to get the shit. The buck stops at you. If you are a certain personality you can accept it, otherwise you will go and become a part-time city GP where, any time there is a potential problem, you write a referral to somebody (AMGP10).

This sense of responsibility increases in a climate of medical accountability where the threat of litigation for rural GPs' is often greater if they, rather than

specialists, undertake procedural work such as obstetrics. However, any negative effect of such expectations is further compounded by a medical culture that falls short of coping well with doctors' experiencing stress. Any institutional ethos of caring for colleagues in need of support from other medical practitioners is often absent (a'Brook, 1990; McKevitt & Morgan, 1997; Sexton, 2002). The inability to cope is considered an unsuitable trait in the medical profession where illness is seen as acceptable for the patient but inappropriate for the doctor and therefore it is often resisted or denied. The doctor as patient is considered an anomaly (McKevitt & Morgan, 1997). One older GP found a way to cope with stress as a young doctor was to work less. This choice was unacceptable to his medical colleagues from whom he received little support:

Most of my peers said if you are not going to [pull your weight], get out of town, you shouldn't be doing medicine as a man (AMGP10).

Attitudes where the doctor as patient was seen as an anomaly were not uncommon in practice. Regarding the stress of work, one older GP enthusiastically commented:

I love the stress. The more stressed you are the more excited you are, the more involved you are, the more proud you feel when you have done something that you know is difficult (AMGP11).

Another response was more tempered but nevertheless reflected the need to carry on working despite being ill:

You don't let your colleagues down. You soldier on. We don't see anything abnormal or unusual about that. No doctor here has ever committed suicide (AMGP9).

However, for GPs who had persisted in working despite increasing stress, serious implications ensued:

I just got more and more stressed. I didn't know I wasn't managing. I just one day said I am not doing this any more and left town (AMGP5).

Given the constraints within medical culture of doctors' coping appropriately with stress, one GP's dubious solution to the stress of overwork

was to work more: 'working is a relief from stress' even though, in his professional environment, he felt 'hounded, persecuted and harassed' (AMGP13) by the government. This affected his sense of wellbeing and had a detrimental effect on his relationships with other health professionals. When asked whether he was concerned about the effects of stress on his health, he responded: 'I haven't burnt out. I just carry on'. The experience of burn-out in another GP, who took several months off work, led him to reflect on the implications of not managing stress effectively:

I didn't go to the doctor and say "I'm burnt out". Everyone could see I was burnt out. Nobody told me I was burnt out. My patients kept saying "you look after yourself." Eventually, for lots of reasons, I got too tired. I forgot to smile but I still had the insight to leave and go away for six months but I still didn't seek help. I was quite unwell. It took me about four weeks to just stop pacing (AMGP6).

A disturbing aspect of this experience was the lack of attention given to this GP by medical colleagues who either did not see, or did not respond to his stress. When asked about their responses, he commented:

Nothing. I don't think they were ever aware. I don't know. I don't understand it. I know there was another doctor in town who got depressed and he said everybody just watched him (AMGP6).

On further reflection, he justified the lack of attention paid by medical colleagues in his own practice:

Within your own practice you don't see that much of each other. We do have meetings once a week but we never discussed that sort of thing. It's a male ego thing, isn't it? It is not really a culture of caring for each other. Having cared for [patients] you tend to just stop. Enough. You are at a meeting and it is relaxing and you are not analysing each other. I don't know whether we all put on facades. I don't know. I have thought about it a lot. It is interesting how, within a practice, no one can see [if another doctor is experiencing difficulty] (AMGP6).

Health professionals and staff working within a general practice may also choose to ignore the fact a GP may be experiencing difficulties given the his dominant

position in organisational structure of the health care hierarchy, further isolating the GP:

You're the boss, the doctor, the top of the hierarchy and nobody tells the boss what they can see (AMGP6).

Factors contributing to stress within rural general practice are being increasingly recognised with calls for a balance between work and home particularly from female medical practitioners. According to one GP, a generation ago a GP's 'whole life was medicine' (AMGP10). Now, younger GPs are more aware of the need for 'self-preservation' by having 'less tolerance of horrible on-call hours' (AMGP12) and more emphasis on 'self-care' (AMGP3) reinforcing the notion that medicine is becoming more of a job than a vocation. One younger GP commented:

We tend to look after ourselves better. ... There has been a cultural shift. There is a lot more awareness about what is necessary to function well (AMGP12).

One important area that can contribute to a sense of wellbeing is that of personal relationships.

## **Personal relationships**

The life of a rural GP who works long hours would be difficult without the support of a spouse/partner. A survey in South Australia found that 45 per cent of rural GPs have virtually no other person, other than their spouse, with whom they feel comfortable discussing personal or professional problems. For those who are in crisis and reluctant to seek help, having a trusted confidante is considered essential for their emotional wellbeing (Sexton, 2002). However, the demands of a rural GPs' work often placed great stress on the spousal relationship:

I think it is very difficult for doctors to sustain relationships, or meaningful functional ones. For starters, they are not there a lot of the time and when they are there they are often stressed over other things (AMGP5).

These sentiments were supported by another male GP who ruefully commented on how he managed the demands of work and family:

I haven't managed them very well. General practice takes over without you even realising it. ... That encroaches on your life at home because you get grumpy and tired. ... Most partnerships last really well. We were talking at a party about whether my wife ever got angry with me. She didn't get really angry with me. She was disappointed with me not coming home, having her conversation with me interrupted by the telephone call from the hospital, disappointed because I was so tired having been up all night and come home for breakfast and go to work and there was no time to chat. So there is this constant strain in your partnership. ... My wife also felt a little powerless because I am not always inclined to take her advice. There is always a tendency to go beyond the point where you fail to see the obvious and fail to take advice (AMGP6).

In a study on doctors' wives in Florida, Nelson (1978: 586) quotes Harrison's findings where the work ethic of doctors is seen as a 'demanding mistress who always wins'. This theme is reflected in the comments of one GP who expressed the tension of juggling the demands of home and work where general practice effectively becomes 'your second marriage' which is 'always a problem':

How do you blend it? I don't know. You usually find you try to keep the working marriage working, because if that falls apart you are in big trouble. ... You try to keep that one working and you try to do the best you can at home (laughs). Sometimes it gets a bit dicey (AMGP7).

When children are involved, there is often even less time together as a couple (AMGP8) and, according to an older male GP, 'you have to have a very special woman' (AMGP11) to withstand the demands of being in a committed relationship with a rural GP. Marriages or committed relationships generally fell within traditional gender lines with the male GP as provider and spouse, ideally, as an understanding and supportive caregiver. Whether the experiences of spouses reflect this assumption will be discussed further in Chapter 8. Despite the stresses and strains of rural general practice, responses showed that few GPs wanted to leave.

### **'Rural practice is probably general practice at its best'**

The sentiments that 'rural general practice is probably general practice at its best' (AMGP2) expressed by an Australian trained, male rural GP were not

uncommon and indicated the great sense of satisfaction many GPs derived from their work in this context. The same GP also suggested that 'rural GPs have better morale, better incomes, and more fulfilling professional lives' (AMGP2) challenging negative views of rural general practice. He had been practising in a rural area for over five years and felt that the combination of lifestyle, diversity of practice and continuity of patient care contributed to his enjoyment of general practice. Several male colleagues of all ages echoed his sentiments and valued being able to practise 'integrated medicine' (AMGP8) in a location close to home, in an 'excellent clinical environment' where the GP is in touch 'with every level of patient care' (AMGP9) from 'the cradle to the grave' (AMGP7). One GP commented that just seeing the 'coughs and colds of city practice would be 'awful' and could lead to deskilling (AMGP7). He considered rural general practice a much better option to practising as an urban GP. The opportunity to do procedural work such as surgery, anaesthetics, emergency care and obstetrics was a factor that attracted many male GPs to rural general practice and influenced their decision to remain:

If I am blocked from doing that I will probably leave. I have spent a lot of effort, time and my family's time and money in gaining the skills and I don't actually want to be in a place where they won't let me practise them (AMGP6).

Some male GPs were bemused, and annoyed, at the financial incentives considered necessary to attract GPs to work outside the cities, as if to compensate for the sacrifice they were making. Most were proud to be rural GPs and rural general practice was often their first choice, made without the need for financial inducements:

Coming to the country was never considered by me to be anything unusual. It was a natural choice. I don't know what all the fuss is about, as if there is something strange to choose to work in the country, as if there is something abnormal about us. I chose the country for hedonistic principles. This is where happiness lay for me (AMGP9).

For others, rural practice was only an option if there *were* generous financial inducements and a 'very good lifestyle; (AMGP3) where 'there needs to be a strong push to make those places more attractive' (AMGP12). The way to attract

more GPs is seen to concur with the notion that GPs need to be compensated for working in a rural area that is perceived as deficient in supporting the work and lifestyle needs of GPs and their families. The solution to offer compensation by providing generous incentives implies the elite status of medical practitioners, reflected in their sense of entitlement in making such demands and having them met. This view does not explore the notion that the expectations of GPs might be unrealistic and warrant examination.

Kamien (1987: 41) found that most rural GPs in Australia were ‘mainly from middle or upper-middle class’ and would therefore ‘miss the trappings of middle class society’ by living and working in a rural area. Economic policies to restructure and develop rural communities have led to services being downgraded or withdrawn which has inevitably led to people leaving to find employment elsewhere (Tonts, 2000). Indeed, research suggests that rural GPs often cited the lack of services, few opportunities for paid employment for their spouses/partners, limited educational opportunities for their children and heavy workloads as constraining factors to working in rural areas (Strasser et al., 1997; Wainer, 2002).

### **The rural GP and the local community**

One GP commented that downgrading or withdrawing services from some locations as part of the economic restructuring and development of rural Australia did exacerbate the problem and ‘[took] the middle class out of country towns’ (AMGP10). He argued that professionals leaving rural locations led to the shrinking of local social networks for GPs and their spouses, making living and working in a rural location less attractive. However, larger centres offered more choice of services: nine of the 13 Australian trained male GPs interviewed lived and worked in Albany which had many attractions, providing opportunities to meet their social needs compared to smaller rural towns. Despite this, there were disadvantages to being a big fish in a small pond.

One GP reflected on the drawbacks of being in an elite position in the social order of the community. He claimed that some rural GPs isolate themselves from the rest of the local community by viewing themselves as different and entitled to certain advantages:

I think part of the problem is that a lot of doctors feel they can't mix with anyone else. They have to mix with the elite of society, lawyers, architects. I think they miss out by not mixing [with everyone] where you realise you are not the most important person (AMGP1).

Such a response suggests that some GPs' expectations of rural general practice focus more on what the community can do for them to make their experience enjoyable rather than what they can do for the community. This implies a sense of entitlement to have certain expectations met because of their privileged social position. Yet, according to one GP, this expectation could prove counter-productive in terms of GPs life experiences and understanding of broader social issues. He suggested that medical colleagues who live in a privileged environment were less able to appreciate and understand the negative experiences of those in the community detrimentally affected by such issues as rural restructuring and development:

For a lot of [GPs] they have no real experience of things like poverty. If you take a group of doctors: they grow up in a middle class background, go to a middle class school, attend a middle class university and then they work in a middle class area. How would they really understand how to get involved because they haven't had the training or had any personal experience (AMGP10)?

Another GP argued that structural factors reproduced the dominant position of rural GPs in the social order. He considered the division between the local GP and the community was reinforced institutionally. Policies continued to reflect the hegemonic status of GPs in the delivery of rural health services by offering them generous incentives and assistance to live and work in a rural area, incentives not offered to other workers. He thought this misguided:

Do [I] feel the need for all this support? Do pig breeders have a support groups?. ... RDAA (Rural Doctors' Association of Australia) sends stuff out to our wives saying "Myrtle is coping at Mukinbudin against all odds". Ridiculous. We are ordinary people who fit into the community. All this is separating the doctors from the community and making them an elite (AMGP9).

This raises the question of value attributed to work status in a rural community. The same GP bemoaned the fact that GPs now expect financial incentives to work in rural locations reinforcing their elite status:

I am not more special than anyone else. I am doing what I like doing. I didn't come here and expect the town council to turn on receptions and buy me a house and a car and a jarrah dining room table. Those incentives are over the top because the doctors have pushed it. Doctors want their 4WDs and luxurious houses. Because of the shortage of adequate doctors they have put more stress on local people to pay for them (AMGP9).

Nonetheless, research has shown that unless adequate incentives are offered that suitably reflect GPs' position in society, most would not consider living and working in a rural location. Because of their elite status and the shortage of GPs in rural areas, some GPs feel justified in expecting generous incentives from government:

The only way to attract someone is by money or a very good lifestyle or to force people to go there which is what the government is trying to do with the new training, or provide OTDs which is the cheapest way rather than offering some sort of subsidies. I don't think they are any closer to solving the problem (AMGP3).

Indeed, smaller centres, especially those supporting a solo GP, often oblige with offers of free or subsidised housing, car, equipped surgery and other incentives that are allocated from their annual budget. However, there were other disadvantages to having an elite status in the community. Some GPs felt they were expected 'to be perfect, and if not, we [the local community] want to know why' (AMGP10). Practising 'perfect medicine' (AMGP10) warranted:

...being on tap 24 hours a day and never having holidays. I think it is getting worse. When you go away people think you have abandoned them (AMGP5).

One GP suggested that the government also expects 'gold standard medicine on copper plated costs' (AMGP10). When mistakes are made in clinical practice, the rural community holds the rural GPs accountable which can make some GPs feel like they are living in a goldfish bowl:

You can't hide. In the city you can hide, you can hide your mistakes. Even specialists hide their mistakes and problems because their numbers are so huge. In the country specialists can't hide their problems. They have one problem and everybody knows about it. You just can't hide (AMGP7).

The idea that 'if you make a mistake you can't hide in small community' (AMGP8) suggests a level of exposure that makes any degree of anonymity difficult in a small location which creates its own set of pressures. The experience of being part of the community is intensified, particularly as some GPs commented that the community 'feel like they own the doctor' (AMGP8). This had implications regarding the boundaries between professional and personal life:

You don't have a choice if someone is having a baby or having a heart attack. A mother turns up with a kid at night-time. It is not an emergency to me but it is to them. For me to say 'go away' is an option but it is fairly difficult to say that to a distressed human being who has probably had a kid screaming all day. I guess you can but, looking at life compassionately, you don't (AMGP5).

Nevertheless, while there was a cost to pay in terms of workload, lack of anonymity, expectations of high standards of work practices from local residents and striking a balance between work and family life, most of the GPs I interviewed derived enormous pleasure from their work, their lifestyle and planned to stay in a rural area. When asked why more urban GPs were not attracted to work in rural locations one GP replied:

I have absolutely no idea. I am glad they don't want to come. I am very happy if they stay in the city. If you go to the country you have to know what you are on about. You have to know your limitations and you generally have to be pretty good at what you do (AMGP7).

## **Future of rural general practice**

Suggestions to improve the distribution of general practice services include allocating Medicare provider numbers according to geographic location so doctors practise where they are needed, rather than providing all doctors, once they have met their training criteria, with unrestricted provider numbers allowing them to practise in a location of their choice (Hamilton, 2001). However, such

suggestions have generally been vehemently opposed by the medical profession. Allocating provider numbers geographically is considered by many doctors as 'civil conscription' by the government and therefore unconstitutional (see Australian Medical Association, 2001b). Some responses from rural GPs support this view considering it 'draconian' (AMGP8) and 'anti-constitutional' (AMGP10). Others, however, responded more reflectively. One GP thought geographic allocation, while restricting the number of GPs practising in one area, could lead to those GPs with the provider number exercising a monopoly in a specific location:

It gives a huge amount of power to the government and to the GP who has a license for a certain area and no-one else is allowed to have one out there. I think that is very restrictive and the system stinks. ... If I hold the provider number in a particular area then the people there get what I serve up. They have no choice as I have the license. ... [The government] can say 'you can't be in Wyvern Village (pseudonym) because there are already four doctors there but you can be in Sunny Bay (pseudonym)'. I might not want to be in Sunny Bay so you get a disgruntled GP in Sunny Bay. It is the enforced licensing to geographical areas which limits everybody. I think the free market is a better option (AMGP6).

Another GP thought that a better solution to cope with the maldistribution of GPs was for the government to:

...allocate provider numbers to the practice, so the practice has a provider number rather than the doctor. That would lock practices into areas, whereas doctors are mobile. When you have a practice provider number you can go and work there (AMGP7).

This GP suggested that if a rural location needs five doctors, the practice is given a provider number that it allocates to the GP for the length of time he/she practices in that surgery. He argued that this offered a more effective solution. Currently, a GP with an unrestricted Medicare provider number has the right to set up practice anywhere, regardless of the numbers already practising in the same location, making maldistribution more likely.

However these responses still prioritised the hegemonic role of rural GPs in health care delivery, a role currently supported by local communities, where

enlisting the services of a GP was considered the most desirable option when considering rural health services. There was little critical analysis of the efficacy of this view in relation to the diversity of needs between communities and expected health outcomes. Services offered by other health professionals were seen as second best. Nurses were generally seen to fill the gap until a GP was available. Despite this, one GP did express the need to think outside this square:

We need people who have a vision and a desire for the health of the community to improve. We need to have people thinking in the bigger picture rather than doctors saying we want this and that (AMGP1).

Whilst some Australian trained male rural GPs are resisting structural requirements that challenge their autonomy and control over their work practices, others are becoming more reflective and considering other ways to approach rural general practice as a result of such changes. These included moving towards creating a balance between home and work. However, despite most doctors expecting to remain in rural general practice, there remains a shortage of GPs. Given the reluctance of Australian trained doctors to work in the country, vacancies are being filled by overseas trained doctors, a theme discussed in the next chapter.

## **CHAPTER 6**

### **Overseas trained doctors and their spouses in country general practice**

Australian trained medical graduates are reluctant to work in rural locations and overseas trained doctors (OTDs) are increasingly being relied upon fill the gap in those areas (Donovan, 2003; Roach, 2003). The Commonwealth government's recent Medicare Plus package projected an extra 725 full-time OTDs to be recruited by 2007 at a cost of \$432.5 million (Australian Government Department of Health and Ageing, 2004). Such a boost to current numbers reflects the dominant role the medical profession plays in rural health care delivery. Any diversity in health needs between rural communities is subsumed under a 'one-size-fits all' approach and the belief that a rural community needs a GP.

OTDs currently make up about 25 per cent of the medical workforce in Australia (Australian Medical Workforce Advisory Committee, 2005). Unpublished data from the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) indicate that, whilst most OTDs gained their medical qualifications in the United Kingdom and Ireland, many are recruited from South Africa. Increasing numbers are now being drawn from Asia, particularly India, Pakistan Sri Lanka, Malaysia and the Philippines (Birrell & Hawthorne, 2004: 91). Whilst studies have focused on ways to attract and retain rural GPs, limited research is available on the expectations and experiences of OTDs living and working in rural locations, and the factors influencing their decision to stay or leave. This chapter addresses the relationship between structural factors and social practice to address this issue. First, it provides a brief overview of the role structural issues play in enabling OTDs to practise medicine in Australia. Second, it focuses on social practice in light of political and economic factors and gender relations by examining the actions, expectations and experiences of 12 male and two female OTDs working in rural locations within the GSDGP. The experiences of 11 spouses of OTDs are also briefly discussed

though they are covered more extensively in Chapter 8. The chapter begins with a structural background, focusing particularly on political and economic factors, in which to locate the increasing use of OTDs in providing rural medical services.

### **Rural medical services and the employment of OTDs**

The mid-1980s saw the numbers of OTDs entering Australia escalating (Birrell, 1995) with doctors arriving initially from the Britain or Malaysia followed by non-Commonwealth countries including the Middle East and Asia (Birrell, 1997). In the 1990s, the government alleged an oversupply of medical practitioners in urban areas. AMWAC claimed that metropolitan centres were over-supplied with doctors at the expense of an undersupply in rural areas, evidenced by increasing numbers of doctors and declining doctor/patient ratios (Australian Medical Workforce Advisory Committee & Australian Institute of Health and Welfare, 1996).

Birrell and Hawthorne (2004) refuted these results and supported findings from research by Access Economics (2002), commissioned by the AMA, claiming there was an overall undersupply and maldistribution of medical practitioners. Birrell and Hawthorn argued that the Australian Medical Workforce Advisory Committee (AMWAC) was incorrect in assessing an oversupply and maldistribution of doctors rather than an overall shortage. They also indicated that government concern over budgetary costs led to legislation in 1996 being passed which restricted the rights of locally trained doctors graduating after 1996 to bill the Medicare system for patient services they had provided. These restrictions also applied to OTDs gaining Australian Medical Council (AMC) accreditation after 1996. Eligibility for these groups of doctors to bill Medicare rested on completing the Royal Australian College of General Practitioners' (RACGP) post-graduate, family medicine program. A quota of 400 new entrants onto the program was imposed, later raised to 450 in 2003, which effectively led to a slower increase in GP ranks. Prior to this legislation, any locally trained or accredited OTD could obtain a Medicare provider number as a GP. The Commonwealth government further reduced the number of doctors by preventing overseas students trained in Australia and doctors from New Zealand

from accessing the Medicare billing system until ten years after registration as a medical practitioner in Australia (Birrell & Hawthorne, 2004).

Birrell and Hawthorne (2004) argued that, since the 1990s, there had been a systemic problem of supply, rather than maldistribution, where the output of medical graduates had not met the demand in general practice, the hospital system or various medical specialities. This had resulted in shortages in rural general practice. Such a development led to increased pressure on the Commonwealth government to address the problem of undersupply, eventually resulting in the Medicare Plus program being introduced in 2004. According to Birrell and Hawthorne (2004), this change in direction indicated that the Commonwealth government's acceptance of AMWAC's 1996 findings was, in fact, misguided. The Commonwealth government now planned to increase the number of medical school places to meet long term supply needs as part of the program. This included opening five new medical schools in Australia.

One short-term solution to the problem of doctor supply advocated by AMWAC was to use temporary resident OTDs to fill the gap in services in those areas unable to attract Australian trained medical graduates (Australian Medical Workforce Advisory Committee, 1999). This policy, which looks set to continue indefinitely, was considered necessary to provide medical services in rural locations, at least until sufficient local graduates fill the places. In Western Australia, many hope that opening a graduate medical school at Notre Dame University in Perth in 2005 will help to redress this problem long-term, particularly given its focus on filling positions for general practice in areas of need.

However, what is not addressed in the discussion is the assumption that increasing the number of Australian trained medical graduates will provide a long-term solution to filling vacancies for GP positions in rural areas. Repeated findings have shown that Australian trained doctors are reluctant to move from the cities and governments cannot insist they work in areas of need without contravening the Australian constitution which prohibits any form of civil conscription (see Australian Medical Association, 2001b; Rural Doctors' Association of Australia, 2003a). There is no guarantee that new cohorts of

Australian trained doctors, once they meet the requirements of practice, will want to work in a rural area of unmet need, so the problem may well persist. Despite governments offering numerous incentives to encourage GPs work in rural areas, including retention payments, relocation grants, grants to work in isolated areas, training grants, locum support, individual and family support, GP positions in many rural towns remain vacant. In the interim, the number of OTDs being employed has increased to fill the gap (Birrell & Hawthorne, 2004).

Various initiatives have been implemented to attract more OTDs to work in Australia. OTDs are now included in the Department of Immigration and Multicultural and Indigenous Affairs' (DIMIA) Skilled Migration Program as a way to facilitate easier entry into the country. OTDs' inclusion in the program requires that their medical qualifications are accepted as eligible by the RACGP. Another proposal in the late 1990s used increased Commonwealth government funding to help the states and territories in Australia set up recruiting agencies to attract doctors to fill vacancies in rural areas. This resulted in the number of Category 422 visas being issued increasing from 664 in 1993-4 to 2496 in 2003-4. Category 422 visas are those issued to temporary resident OTDs for up to four years on the proviso that they work in an area of need designated by the state and territory in which they work. While most OTDs with these visas worked as GPs they were not required to have their medical qualifications assessed by the Australian Medical Council (AMC), a change that also included OTDs on Permanent Resident Visas (PRVs). This was not considered a problem as most OTDs with 422 visas were 'recruited from Britain or other Commonwealth countries' (Birrell & Hawthorne, 2004: 90). However, Birrell and Hawthorne (2004) argue that it is now becoming a problem as increasing numbers of overseas medical graduates are recruited from elsewhere where English is not their first language, some of whom have struggled to pass the AMC accreditation exams. Programs designed to assess and train OTDs to the standard required to pass the exams have been implemented in each state or territory rather than nationally. The exams themselves are also being modified.

However, some concerns about the Medicare Plus program have been aired. Birrell and Hawthorne (2004) agree with the Australian Doctors Trained Overseas Association (ADTOA), the peak national organisation for international

medical graduates in Australia, that any assessments of suitability are not biased against those from non-English speaking backgrounds (NESB). However, all agree that some form of assessment is necessary to practise medicine in Australia. Birrell and Hawthorne (2004) suggest some overseas based medical training may not be sufficient preparation to work in Australia and meet the characteristics of Australian patients' health profiles.

This raises the question of what constitutes adequate preparation for OTDs to work in rural Australia and to what extent are cross-cultural issues examined in the delivery of medical services? While the Australian Rural and Remote Workforce Agency Group (ARRWAG) (2004: 4) recommends that the development of assessment criteria should be consistent nationally and meet the 'standards of the learned colleges and university medical departments', other factors beyond medical training also warrant consideration. ARRWAG suggests that appropriate professional and personal orientation is necessary to familiarise OTDs with Australian rural culture. Cross-cultural understanding seems particularly relevant for those working in areas with high Aboriginal and Torres Strait Islander populations.

Doctors' cultural expectations, values and religious beliefs need considering particularly if they impact on health outcomes. Anecdotal evidence of rural GPs in solo general practice who are reluctant to prescribe contraception to teenagers based on their own religious beliefs, is a case in point. Patients in this instance may have limited options to seek other advice due to lack of access to services. Such a response raises issues, not just of the interface between a doctor's religious beliefs and medical treatment, but also of the impact of rural restructuring on limiting access to appropriate services that may affect patients' health outcomes. If high quality medical care is a goal for rural communities, then appropriate training for OTDs working in culturally, linguistically and geographically diverse areas is necessary.

Seeking ways to help OTDs and their families adapt to their new lives is also important and local communities are encouraged to support and help them settle in (Australian Rural and Remote Workforce Agencies Group, 2004). An initiative established in the early 1990s to facilitate that process was the Rural

Medical Family Network (RMFN), which offers social and emotional support to all rural medical families who are experiencing difficulties living and working in a rural location (Delane, 2002).

Selecting and recruiting OTDs is currently carried out by private companies as well as public sector agencies (Birrell & Hawthorne, 2004). One of the most successful initiatives to increase the rural GP workforce was introduced by the Commonwealth government in 1999. The Five Year Overseas Trained Doctor Program, discussed in Chapter 2, offers various incentives for OTDs to work in rural practices. The program has attracted approximately 250 OTDs eligible to work in Australia (Australian Rural and Remote Workforce Agencies Group, 2004). Yet, despite efforts to match the demand for medical services with workforce supply, Western Australia continues to fall short of medical practitioners based on population ratios. This is significant particularly as the state's population is predicted to grow to 2.3 million, a growth rate that is nearly double that of New South Wales and Victoria, suggesting that the reliance on OTDs to provide medical services is set to continue (Australian Medical Workforce Advisory Committee, 2005). The relatively low number of medical school places in Western Australia, compared with other states, is considered to be a major reason for the ongoing and growing reliance on OTDs, particularly in rural areas (Australian Medical Workforce Advisory Committee, 1999). OTDs perform a vital role in Western Australia where approximately 40 per cent of all rural GPs qualified outside Australia (Western Australian Centre for Remote and Rural Medicine, 2003). This leads us to consider how OTDs and their spouses have responded to structural constraints and adjusted to their new lives in rural Western Australia. The responses of those living in the GSDGP are now explored.

### **OTDs and their spouses: life and work in rural Western Australia**

Interviews with OTDs and their spouses/partners living and working in rural settings paint a diverse canvas of the diffusion of cultures. Differences in ethnic and professional backgrounds between doctors and their families intersect with differences between geographical locations and the communities in which

OTDs and their families live and work. This picture questions any notions of homogeneity when considering the concept of rural general practice. Threads of diversity run through OTDs' and their spouses' responses to settling in to their new lives even though commonalities exist. A noticeable theme emerging from participants' responses was a sense of cultural dislocation as participants adapted to the unfamiliarity of their adopted environment. Such feelings were offset by OTDs' enjoyment of their work and the welcome they and their family received from the community in which they lived. This type of response helped to foster in OTDs and their spouses a sense of belonging to the community. Both these factors often strengthened their resolve to remain in a rural area. An added bonus and contributing factor for GPs to remain were the opportunities to carry out procedural work in rural general practice. Several had worked in a rural environment before arriving in Australia and were experienced procedural doctors (see Table 11).

However, a significant factor that dampened OTDs' enjoyment of their work was the role structural forces played in clinical practice. Responses revealed tension and frustration as they, along with their Australian trained colleagues, struggled to come to terms with the level of government regulation and the threat of litigation in general practice. Bureaucratic requirements placed significant demands on their time, considered unnecessary by some OTDs. Increased calls for accountability and the very real threat of being sued led many OTDs to also practise 'defensive' medicine to protect themselves; they often ordered more investigations on their patients than they thought were necessary. According to one OTD, 'every patient is a potential legal battle' (OMGP8).

Responses of spouses of OTDs to living in rural Australia were mixed. They ranged from profound relief to finally live in a safe environment, where the threat of danger was perceived as virtually non-existent, to deep appreciation for the welcome and support they received from the local community in which they now lived, to grieving for the loss of a country, family and friends they loved. Some found the transition easier when their sense of isolation and cultural dislocation were tempered by meeting other ex-patriots living in Western Australia. Structural factors also impacted on their expectations and experiences living in a rural area. Most spouses conformed to conventional gender roles with

the woman as main caregiver, responsible for domestic tasks and the man as provider. Some female spouses prioritised this role and chose not to enter the paid workforce or they worked part-time in an occupation unrelated to that in which they were trained. Others, the minority, resisted such expectations to deny or minimise their professional or occupational aspirations. Instead, they attempted to pursue their chosen careers despite their frustration at the difficulties they encountered including the effects of geographic isolation on the availability of opportunities. In the process, they often felt frustrated at the difficulties they encountered when attempting to pursue their careers not least the effects of geographic isolation on opportunities. All female spouses of OTDs gave a high priority to their role as primary caregiver. Male spouses, on the other hand, actively pursued their career interests which often led to their GP partners working less and taking on the primary caregiving role once the men found full-time employment. Any reversal of roles where males took on the role of caregiver was considered temporary until they found full-time work.

Interviews were conducted with 14 OTDs, 12 males and two females from different countries in Asia, Europe and Africa who had lived and worked in rural Australia from three months to 15 years. Eleven spouses, nine females and two males, also agreed to be interviewed. The average age of OTDs was 48 years and spouses 43 years. Small rural and non-coastal group general practices in medium rural centres were staffed predominantly by OTDs. Six OTDs worked as solo GPs in small rural locations and seven worked in group practices in medium sized rural centres with only one working in the large rural centre, Albany. Male OTDs interviewed comprised 27 per cent of male GPs in the GSDGP and female OTDs made up 13 per cent of all female GPs working in the Division. Over 50 per cent of OTDs interviewed were part of the Five Year Overseas Trained Doctor Program. All but one participant were married or in committed, long-term relationships. However, one spouse had returned to her country of origin and another lived in Perth with her child and the family saw each other at weekends. One OTD worked four days a week in a rural location but lived with family elsewhere for the rest of the week. Interviews explored participants' responses to factors influencing their transition to life and work in rural locations within the GSDGP and factors contributing to their decision to stay or leave.

Several South African trained doctors had previously worked as rural GPs and were often experienced in procedural work having been required to work in public hospitals as part of their training. In this context, most had delivered hundreds of babies and performed numerous Caesarean sections. They were also surgically experienced with skills in orthopaedics and emergency trauma as well as anaesthetics. Some had also made the transition from being solo practitioners in other small Australian rural centres to living and working in medium-sized rural towns where they could practise as procedural GPs and do ‘what we were trained to do’ (OMGP 10). One had transferred interstate from a rural group practice to become a solo GP in a small rural centre. OTDs trained in South Africa constitute a significant diaspora in the GSDGP offering each other cultural, social and professional support. This factor contributed significantly to the settling in process by lessening the sense of isolation and loss of family, friends and culture following their migration to Australia. OTDs from other countries were often not so fortunate and the transition was more difficult.

### **In their own words**

#### ***‘Push-pull’ factors attracting overseas trained doctors to work in rural Western Australia***

A combination of ‘push/pull’ factors led many families to come to Australia. They ranged from a sense of adventure, to wanting to leave the political and economic climate in their countries of origin because they saw ‘the writing on the wall’ (OMGP10) in terms of diminished hopes for the future, to wanting to escape an environment where their lives were at risk. Moving to Australia offered hope for the future, a safer lifestyle, better prospects for their children’s education, opportunities to practise procedural medicine and the challenge ‘to do something different before we get too old’ (OMGP5). However, the transition was not always easy. Some OTDs and spouses were deeply affected by a feeling of dislocation from their country of origin, their culture and their extended family, others were subjected to racial taunts and some spouses were frustrated at the lack of employment opportunities to pursue careers in their chosen field. These experiences were softened when local towns welcomed

OTDs and their families and valued the contributions they made to the community.

The opportunity to work in ‘one of the best [medical] systems in the world’ (OMGP4) where facilities were good and the Medicare system guaranteed an income for the doctor was a significant ‘pull’ factor. This was enhanced by the sense of relief and gratitude to be living and working in a secure environment that was not underpinned by a culture of fear. Despite any difficulties, most participants agreed that the advantages of staying in rural Australia outweighed those of leaving and returning to their countries of origin.

### *Security*

One of the main reasons for leaving their countries of origin was the lack of security and the constant stress of living in fear, particularly for those who had lived and worked in Southern or Eastern Africa. Some arrived in Australia with few funds due to poor exchange rates or prohibitions on taking currency out of their country of origin. One spouse had hidden money in a suitcase because of constraints withdrawing it from the bank. In order to be able to leave the country as a family, she had smuggled enough money to a relative in another country to buy the family’s air tickets to Australia. Other families had left terrifying conditions, including home invasions, armed burglaries, hijackings or living in security compounds that felt like ‘we were always on the defensive; prisoners in our own gaols’ (OFSP7). Many saw security in Australia as a non-issue, relative to their experience back home, with one spouse commenting: ‘most Australians don’t appreciate what they have’ (OMSP2). According to one GP:

In South Africa people are under political stress, economic stress and the stress of change...There is very little stress here. I don’t think people in Australia realise how fortunate they are. If there is a murder in Australia, it is headline news. There are twenty to forty murders a day in South Africa and they often don’t make the paper (OMGP3).

One GP gave the increasing rate of HIV/AIDS in South Africa and increased risk of a needle stick injury in his clinical practice, along with the fact that the family home had been burgled, his sister hi-jacked and his friend’s surgery bombed, as some of the ‘push’ factors that led him to leave the country.

Another GP left his country ‘because he had to, not because he wanted to’ (OFSP2) when he realised there was no future for his children.

### *Incentives*

GPs with young families chose to come to Australia to live in a safe environment and to improve their children’s prospects:

The whole time we are reminding ourselves that we made the change for the children and if they are happy, fine. We might never adjust, but the children will, and that is OK. They are very happy. I worried so much about them and I didn’t have to. I should have worried more about myself! They are very, very happy and the schools have been good (OFGP 2).

Other pull factors included good working and living conditions. Several OTDs had contacted a recruiting agency to work in rural Australia. In most cases, the agency contributed to, or paid in full, the air fare of the GP but not the family, to come to Australia. Solo GPs were usually offered rent free accommodation by the rural shire in which they worked. In one town this comprised a large, well-appointed, new, five bed-roomed house and garden with the shire paying electricity and water bills, providing two equipped surgeries and offering the free use of a vehicle, which was also serviced by the shire,. This led to comments from one GP:

Where on earth would you get these types of luxuries? Clean surgery, friendly faces and people that say “don’t leave us”. I tell them they will have a difficult time getting rid of me (OMGP6).

In larger towns with group practices, accommodation and vehicles were generally not free but were sometimes subsidised. Standards of housing were not always high:

The first house we were put in was tiny. Fine. But there were three meat safes in the sitting room. It was only temporary. There was also a surf board on the wall and broken sofas (OFSP1).

Most OTDs who were interviewed worked in private practice. One GP was paid a salary by the recruiting agency with a view to taking over the practice once he had passed the RACGP exam. Another owned his practice but ‘fully

bulk billed for philosophical reasons' (OMGP5). In some locations GPs were required to contribute a percentage of their income to the recruiting agency for management costs in running the practice. According to one GP, this amounted to between 30 and 50 per cent of his income. However, corporations owning and/or managing general practices had its advantages for the GP, not least the opportunity more time to spend with his/her family.

### ***Cultural adjustment***

Most OTDs sought out other compatriots and, where possible, established or maintained pre-existing social and professional ties in a rural Australian context. This often involved travelling hundreds of kilometres during their time off to meet them. Despite the distance and working in different locations, this connection helped the settling in process. OTDs and their families were able to speak their language and experience a sense of belonging and support which lessened the feeling of cultural dislocation and loneliness from being separated from country, family and friends. It also highlighted cultural differences, illustrated in the responses of one GP when invited out locally by Australian families:

A few people would invite us over for dinner and even that would be different, the kind of food they serve. ...You only realise what your culture is once you leave it; the way you eat, the way you do things is different. We missed our food, our own kind of food, terribly. Our best times have been going [to visit] [ex-patriot] friends where we eat as we usually do and talk our language (OFGP2).

Notwithstanding the relief to feel safe and leave behind a culture of fear, and the proximity of other expatriates, some still yearned for their country, family and friends. One spouse who had lived in rural Australia for several years commented:

I ache deep down but still hang onto those things that [reflect] a better life. You miss the smells, the smells of Africa and South Africa (OFSP7).

Loneliness added to the difficulty adjusting to a new life. Some GPs and their families found the transition hard because of cultural, linguistic and religious differences and a lack of extended family and friends. One family was coping

with living in a small rural town with a population of under 2000 where the GP worked in a solo general practice. His wife was unable to work in her chosen profession due to lack of opportunities and no extended family to assist with childcare. They had previously lived in a large, bustling Asian city with a population of several million surrounded by extended family and social networks. Another male spouse with a professional career stayed at home for a year to look after the children while his wife worked. During this time, he found meeting people difficult and his spouse commented that he ‘felt like an alien for the first year’ (OFGP2). A female spouse, who had lived in a rural town for several years, recounted a similar experience when she first arrived:

I had no one, not one person to talk to. I was desperately unhappy. I would stop people on the road and say good morning and start talking to them. I started talking to myself in case I forgot how to talk (OFSP1).

Another spouse, resident for several years in rural Western Australia, recalls her difficulty coping with the shock of moving and adjusting to her new life. She acted as if she were adapting well because ‘I didn’t want to tell them how I had suffered and how I needed help’ (OFSP7). Whilst appreciating the welcome offered by the local community, she ‘just wanted to hide’. Others felt a tension between the need to be appreciative of efforts made by the community and be sociable, and the desire to be alone with their family:

It’s hard. Depends on the kind of person you are. I have always been a very private person and I work with people every day, so at the weekends I just want to be at home and spend [time] with my family. My colleagues have been exceptionally good and invited us to meet other people. But still, I prefer my weekends at home. I haven’t yet met an Australian person where I can say these are my good friends (OFGP2).

Coping with life in a new culture was often compounded by a sense of isolation. According to one spouse, this was helped by contacting the Rural Medical Family Network (RMFN) for support.

### ***Isolation***

One GP experienced the sense of isolation as relative. He and his wife had ‘never lived in a place as small as this’. In Africa, small, isolated locations

were 'ten times bigger than here'. Working helped him to settle in and meet people but the adjustment to a new culture and location was difficult for his wife:

My wife couldn't cope and returned [to her country of origin]. There was nothing for her to do. She had trained [in her chosen profession] and she was bored here with nothing to do. She had always worked and had never stayed at home before [so this was] a big difference (OMGP8).

His response highlights the particular challenges facing unemployed spouses who are coping with the cultural, social and geographical isolation. Spouses who had worked in their country of origin, but were unable to work in rural locations, lost their professional role, financial independence and sense of identity as separate from their GP partner. This loss was exacerbated by the long working hours of their GP partners, increasing their sense of isolation. One spouse from a different cultural and linguistic background was used to working full-time in the profession in which she had trained. Her extended family had looked after the children and she found it difficult to adjust to not working at all and having to do all the childcare. Her husband's long working hours compounded the problem to the extent that 'we are only together in bed' (OFSP5). She had lived in a small rural town for over 18 months and kept herself busy 'reading, doing patchwork and helping the [children] with their homework'.

Even when some doctors and their families made the decision to come to Australia for a sense of adventure or change, the isolation of some rural centres proved challenging:

Ten minutes after I came here I wanted to leave. Maybe it was ten seconds. But I had made a commitment to come and I thought it was unfair to leave. The previous GP from [overseas] stayed for six weeks and left ... If I had looked around and decided what I was going to do in Australia I would not have come to a rural area ... A lot of people who come over here don't realise how isolated it is (OMGP5).

Despite the challenges, this GP had stayed and had worked in the same rural centre for several years. The sense of isolation was cushioned for others by the welcome they received from the local community with one GP commenting that he 'didn't expect this friendliness, open-arms welcome from everybody that we have experienced so far. I haven't had a bad experience yet' (OMGP3). One

OTD enjoyed his work, despite its heavy demands, and spoke of his appreciation at the welcome extended to him and his wife by the local community. Community support fostered a sense of belonging in OTDs and their spouses and emerged as a theme in discussions with other GPs that staved off feeling 'isolated, like a man in prison' (OMGP6) and contributed significantly to the settling in process and overall enjoyment of rural general practice:

On Saturday there was a busy bee and all the staff came to do my garden. Tremendous. Different from back home. People are more supportive and friendly. It makes you feel you are part of [the community] ... Everyone calls you by your first name. It is a very informal structure. I find it perfect (OMGP6).

### ***Social adjustment***

GPs' involvement in social and community activities assisted the settling in process and enhanced the feeling of acceptance, belonging and wellbeing. There were those who welcomed the opportunity to be sociable, threw themselves into voluntary work in the community, helped at 'busy bees' and went drinking at the pub. One spouse who had recently arrived was 'delighted and relieved to be here, and eager to make friends' (OFSP2). A recently arrived GP working in a solo practice enjoyed feeling part of the community where he was invited out regularly:

There are fantastic people around here. I am part of the community. That is the only way you can survive in a community like this. You have to be one of them. If there is a party they call me. If they go to the pub they drag me out. I am part of it (OMGP4).

One family, however, kept clear boundaries between professional and private lives, working, but not socialising in the community. As a GP working in rural practice for several years, he found such boundaries become increasingly blurred as friends 'took liberties' (OMGP5) wanting 'after hours' consultations. He and his spouse eventually chose to keep their personal and professional lives separate and move the family elsewhere once his children started secondary school. Whilst continuing to work in the community, he travelled several hundred kilometres at weekends to go home to his family.

There were other families who wanted to be sociable, but invitations and support were not forthcoming even though local residents were friendly. This was rationalised in various ways from local people having ‘their own networks of friends’ where they ‘didn’t need us’ (OFSP7) to people being ‘scared’ to invite the doctor to their home ‘because I was on-call’ and ‘people have their own cliques’ (OMGP10). Another OTD commented that they had been in town several months and ‘hadn’t yet met our neighbours’ (OMGP9). Others’ experienced a lack of welcome from the medical fraternity:

That sense of welcome is lacking in Australian medical circles where they are all well established doctors and wives. They don’t think “there is a newcomer from a different part of the world”. I don’t think they think (OFSP1).

This sense of marginalisation was difficult for some spouses, particularly if they had limited opportunities to work outside the home. Of the nine female spouses interviewed, two worked part-time, one worked casually in her husband’s surgery and was also studying. Six were not employed in the labour market although one was keen to work when her children were older. Several established a social network through community activities including participation in the local school and craft groups, with one commenting:

There are wonderful organisations here including craft groups. I have made so many lovely friends. I think I have had more friends here than I made in the ten years we lived in [a rural area in country of origin]. The town offers quite an astonishing variety of activities for people living here (OFSP4).

While some spouses adjusted to not being in paid employment, OTDs were faced with the challenges of working in a different medical system.

### **Professional adjustment to rural general practice**

The dialectical relationship between structural factors and social practice is evident in the frustration expressed by some OTDs in the face of rural health services being restructured in the current political and economic climate leading to changes in the work practices of some rural GPs. The downgrading of smaller hospitals prevented some OTDs practising procedural medicine. Others were annoyed that more credence and value was not given to their knowledge,

experience and skills gained in their countries of origin by the medical bureaucracy in Australia. One GP was irritated that he was expected to sit the RACGP exam even though he had been working as a procedural GP in a rural area for over 30 years before arriving in Australia. Bureaucratic requirements in clinical practice, and staving off the threat of litigation for medical malpractice, are challenges faced by all doctors in Australia regardless of their training or place of work. However, the amount of red tape involved in clinical practice was considered excessive, time consuming, and more than most OTDs had encountered in their previous practices. Meeting bureaucratic requirements often led to frustration.

Procedural OTDs in group practices offered services such as obstetrics, surgery, anaesthetics and emergency medicine with some being very experienced in their field. Those in solo general practice, regardless of their expertise, were unable to offer this kind of service due to a reduction in resources when smaller rural hospitals were downsized. As a result, some GPs had made the transition from being solo practitioners to joining group practices in larger rural towns where they could practise their procedural skills. Several commented that the variety of medical practice was a significant reason to remain in a rural area:

One of the reasons I would never be able to work in a place like Perth is because I was trained to be a rural GP and I cannot see myself consulting day in and day out. That would be an insult to my IQ and integrity. It's not just about procedural work in the country. It is about seeing someone with pneumonia, doing an x-ray, deciding the patient has to go to hospital, prescribing the treatment, giving the I/V antibiotics, and following them through till either they are better or I can't handle them any more [and need to refer them on] (OMGP10).

The same GP raised the point that solo practices were 'not sustainable' despite initially being a satisfying environment in which to work:

[They are like] a dripping tap. You cannot be on-call all the time, even if you don't get called out (OMGP10).

Sustainability is only possible if GPs are available '24/7'. However, while he considered this unrealistic, it was not a reason to leave rural general practice:

I don't want to finish the bush scheme to get into the city. I have got no intention going to the city (OMGP10).

Other GPs were used to work practices demanding 24/7 on-call evoking the heroic image of rural general practitioners:

I'm used to that and we are not that busy. You rest when there are no patients and you work when there are patients (OMGP4).

Most, however, whilst enjoying their work, appreciated their time off even if it meant leaving town in order to have a break. However, the requirements necessary for OTDs to practise medicine in rural Western Australia did reduce their enjoyment of work.

### ***Bureaucracy***

Several OTDs were frustrated that bureaucratic requirements underpinning their eligibility to practise medicine did not recognise the diversity in their knowledge, skills, ability and expertise adopting instead a 'one size fits all' approach. Sitting the RACGP exam was mandatory despite some rural doctors having many years experience in their field in their countries of origin. Those who applied for eligibility to practice procedural medicine were irritated by the bureaucratic hold-ups. Most GPs were also frustrated at the amount of paperwork and the level of government regulation and control in clinical practice with a few considering leaving: 'if the bureaucracy becomes too much' (OMGP11):

It came as a helluva shock when I started here because I had never pushed around so much paper. And a lot of the paperwork is really irrelevant. It is not doing anything. We are gradually getting used to it. You can't get away from it with the Health Insurance Commission and all the bloody hoops you have to jump through there. A good example is the Practice Incentive Payments. A lot of hogwash. Why do we have to do care plans [for patients]? We are doing them anyway. I think all doctors do them wherever you have trained. For diabetics we check their sugars, cholesterol and send them to a dietician. That is a care plan in any case. So why call them enhanced primary care items and then get PIP for having a practice nurse, or doing so many asthma checks, or so many immunisations? It is a load of bullshit. We are not going to achieve anything by

doing that. We are doing it to please the bureaucrats (OMGP10).

Added to this, GPs were working in an environment of increasing litigation which affected the way they carried out their clinical work.

### ***Indemnity***

Interestingly the risk of litigation for medical malpractice was not seen as a major problem for some overseas trained GPs, nor was it enough to make them want to give up procedural work. On the contrary, some adopted the attitude that doing ‘what we were trained to do’ (OMGP9) and taking the risk was part of their job, particularly in an emergency situation, rather than succumbing to the fear of being sued:

It was incumbent on me to try and save a life rather than to phone an insurance company and say “will you give me cover?” while the patient deteriorates. So, I don’t care what the insurance or government does. I just handle situations as they arise (OMGP6).

Others commented that the fear of litigation led to practising ‘defensive’ medicine where doctors became increasingly cautious when treating patients and ordered more tests to cover themselves legally. In his country of origin, one GP would take a history, examine and diagnose the patient and use tests only to confirm the diagnosis. In Australia, ordering ‘three times more investigations and tests’ (OMGP3) was preferable to having the ‘finger pointed’ even though this GP thought money was wasted on unnecessary investigations. One solo GP reflected on the stress related to the threat of litigation:

Cost [and the fear] of litigation will influence everyone who is practising medicine. You don’t necessarily change how you practise medicine and continue to practise to the best of your ability but the fear or stress is that there is no guarantee to protect you from litigation and that is a stress. It is the fear of the threat of litigation. If something goes wrong, and even if it is not your fault, someone can sue you and that is your concern. You feel powerless (OMGP7).

One GP commented that a relative already working in Australia said ‘I was mad coming here because of the litigation’ (OMGP11). Government regulation and control over work practice, and the risk of litigation for professional malpractice,

were seen as time consuming distractions from the real work of being a rural GP, which was clinical practice.

### ***Professional relationships***

Support from other health professionals in clinical practice helped OTDs settle into their new work environment. The level of support experienced by OTDs varied. For some, it was outstanding. In one rural town there was a tangible sense of collaboration between hospital staff and local GPs as they negotiated to work for the greater good of the community. The local Health Service Manager/Director of Nursing (HSM/DON) played a pivotal role in retaining GPs trained overseas by supporting their professional needs and proactively establishing and building strong relationships. This included providing refurbished premises for a surgery close to the hospital, negotiating on-call rates and cover to ensure GPs have adequate time off, and organising one of the local service clubs to host a dinner to welcome new GPs and their spouses to the town. A spirit of cooperation and partnership between GPs and the HSM/DON is evident in their responses:

We all need each other. Without [the hospital] he can't do his job; without him, I can't provide health services to the community (HSM/DON).

The DON who runs hospital wants us here so tries to help. If you want something, she is quite open to discussion. She tries her best to find it for you. She even drives long distances to fetch equipment for you. She really goes out of her way. ... We work together really well. We do have our differences, ... but it is always in good faith that things are discussed. It works well and makes a huge difference (OMGP2).

Other OTDs were not so lucky. When support from health professionals was not forthcoming, their sense of anger and isolation increased. One GP commented that, after several years, his medical colleagues had not introduced him to some of the visiting specialists:

There was no attempt made by anyone to introduce me to any of them. And if you make attempts to try and meet them you are considered a bit pushy (OMGP7).

Another GP who enjoys rural general practice and ‘loves the work, the team work and the clinical job satisfaction’ to the point where he feels ‘one hundred per cent satisfied’, has reservations based on relationships in a broader context. Such reservations rest on his perceptions of institutional discrimination that has led to him to consider leaving rural general practice in Western Australia:

You are treated as secondary in Western Australia if you are from Africa. You are not given equal footing and opportunities as those from Europe. That is the truth. It is an unwritten law but it is there. You see, what you are given is quite different from what others are given. Those coming from Europe are given better deals, better treatment based on location, better support, more openness, better information and better financial rewards (OMGP8).

Some OTD also experienced discrimination in the attitudes and practices of some local health professionals, the effects of which spilled over into the community:

The other problem I had was because I came from Africa they thought I would be pretty backward. So, whenever I asked for drugs that were not available in Australia at the time, but have subsequently been made available, I was told that we didn’t have those primitive drugs in Australia. Two and a half years after I was here, I was introduced to the Medical Director by a senior member of staff as “the locum from Africa”. I wasn’t very impressed. ... This attitude has washed off into the community. It does make it difficult sometimes (OMGP11).

Such attitudes led one OTD to state ‘I could never stay here permanently’ (OMGP8).

For recruitment and retention to be successful, understanding and meeting the needs of OTDs in rural areas is necessary. However, adequately addressing those of their spouses is also important. According to Kamien, (1987: iv) ‘rural practice is a family concern and the success and retention of a doctor depends to a large extent on the adaptability of the spouse’. Most female spouses, despite their professional backgrounds, adapted and conformed to hegemonic expectations about the gendered relations by subordinating their own career aspirations to take on the role of primary caregiver in the home, supporting their GP partners and family. While some focused on the importance of this role, others felt frustrated at their loss of professional identity. Male spouses of female

OTDs also conformed to dominant expectations of their role as provider. Role reversal was seen as a temporary measure until they found paid employment outside the home and their GP partner could then work part-time. One female OTD who became the main provider found the transition ‘huge’ (OFGP2) and difficult. When her spouse found full-time paid employment, she reduced her working hours. Her choice highlights the need for future rural medical workforce planning to consider the choices female GPs make to work flexible hours to meet, not only the demands of their other roles, but also to enable their male partners to work full-time.

### **The future of rural general practice**

Some OTDs reproduced hegemonic ideas of health care by envisaging the future of rural health service through a medico-centric lens where the solution to attracting more GPs was to offer them more money:

If you throw money at people they go and chase it. If you pay people enough, they will do anything and will move (OMGP2).

Others suggested the need to increase the number of medical students from rural areas as they were the ones most likely to want to work in those areas. One OTD thought that reassessing the training undertaken by potential rural GPs was necessary, particularly in the light of indemnity:

We are farting against thunder. ... We are not training GPs who feel confident [to do procedural work] in a rural hospital; we are not training holistic doctors who are able to see the full spectrum of patient care, from the cradle to the grave and everything in between. Being able to know a little about a lot of things rather than a lot about a few things [is important] (OMGP10).

Notwithstanding the rise in popularity of technology in rural medical health care with the increasing use of telecommunications, or Telehealth, a more sustainable option considered by some was to move away from staffing small towns to offer medical services in large rural centres as ‘people aren’t scared to travel’ (OMGP10). Alternatively, several OTDs had worked extensively with nurse practitioners in rural settings in their countries of origin and considered

them ‘very experienced ...and extremely competent’ (OMGP1). They openly supported their increased utilisation in rural Australia:

The nursing staff here are well trained. Why don’t we use them better (OMGP1)?

Another sang their praises and believed they would:

...easily be able to take care of a town’s problems, lacerations, all kinds of things without any problems. That is an option (OFGP2).

An older OTD agreed, on the condition that nurse practitioners ‘knew their limits’ where ‘very clear guidelines’ were necessary for them ‘to know that they are not doctors’ (OMGP11). One GP suggested that using nurse practitioners ‘can work well with caution’ as long as their experience was backed up with ‘book knowledge’ (OMGP2). The provision of rural nursing services with adequate medical back-up was considered a solution to the difficulty of attracting doctors.

The dialectical relationship between structure and social practice is evident in OTDs’ responses to political and economic factors impacting on clinical practice. While increased levels of bureaucratic control caused frustration and tension, most OTDs were willing, where necessary, to change their practices to comply with the requirements. However, some intimated that, should levels of bureaucratic control increase, they would consider leaving. While the social practice of gender fell along conventional lines, some female spouses of OTDs were frustrated at the constraints imposed on their lives and expectations by living in a rural location. This led to some to take on the primary caregiving role full-time and, in some instances, to underutilise their professional skills if opportunities to work locally in their chosen field were unavailable.

While male GPs constitute the majority of the rural general practice workforce, the number of women rural GPs is steadily increasing. This development will impact on future rural medical workforce planning as female rural GPs challenge conventional work practices that do not serve their interests, and generally work less hours than their male colleagues (Australian Medical

Workforce Advisory Committee, 2005). The expectations and experiences of female GPs in light of structural changes are discussed in the next chapter.

## CHAPTER 7

### **‘Heroes and fairy wrens’: the social practice of female rural GPs**

Patients build up rapport with a female GP but she is not available on Tuesday and Friday so, if you are sick Friday night, you end up having to see the grumpy old male GP. All he wants to do is knock off, and he’s pissed off because the female GPs are never there when they need to be, when there is a rush on. There’s a bit of a grudge thing because the male GP has to run the jolly practice while females flit in and out like fairy wrens (laughs) (AMGP 6).

At one level, the quotation above paints a picture of a male rural GP who resents seeing the patients of his female colleague because it means extra work for him as she works part-time and is not available. At another, it suggests tension between two models of work practice. The conventional model of Western medicine and rural general practice has always been male centred where an ‘unacknowledged convergence between “medicine” and “male-practised medicine”’(Wainer, 2003: 69) has over-ridden the different needs of women doctors. This hegemonic approach to work practice involving long working hours is currently being challenged by female medical practitioners who want to strike a better balance between home life and the demands of their profession. They prefer to work within a model that allows more flexibility in working hours (Kilmartin et al., 2002; Lippert & Tolhurst, 2001; Pringle, 1998). In a rural setting this is particularly relevant given that childcare services may be limited or non-existent.

This chapter examines calls for changes to work practices by female GPs that intersect with hegemonic ideas of rural general practice. It considers the notion that increasing numbers of female GPs, and their demands for greater flexibility in working hours, are altering work patterns that have historically supported the interests of male GPs in a rural setting. The chapter illustrates that female rural GPs’ demands for changes at work are often predicated on dominant

ideas regarding the gendered division of labour at home. Women still retain the major responsibility for domestic and caring work in Western industrialised countries (Crompton & Le Feuvre, 2003; Hochschild, 1989; Sullivan, 2000). At one level, this is a significant factor contributing to female GPs' wish to work fewer hours. At another, the social practice of gender in the home, with women taking on the role of primary caregiver, intersects with the demands of the workplace causing tension between male and female GPs as women leave early to carry out the 'second shift' (see Hochschild, 1989). The chapter also explores whether women rural GPs working fewer hours is supported by male rural GPs. Hegemonic expectations require women to be the home-maker. Yet if the demands of that role intrude into the workplace, it is the female GP, rather than the organisational structure of medicine, that is held to account for not 'being there when they need to be' (AMGP 6), often resulting in longer hours worked by the male GP.

## **Background**

Socio-economic changes in the last 40 years in Western industrialised countries have led to women's increasing employment outside the home. Their entry into the market economy has altered their lives dramatically (Hochschild, 2003). The institutional structure of many professions has been organised to reflect a gendered division of labour predicated on the male in the workplace as provider and the woman at home caring for the family. Hochschild's (1989) research on the work structure of universities in the United States shows that work practice was designed to meet the needs of males who worked full-time and whose wives stayed home and raised the children. They did not cater for the needs of women who were the primary caregivers and who worked outside the home by introducing flexible working hours to fit in with their childcare responsibilities in the home. Work patterns in the medical profession in Australia have long reflected a male model of work practice (Pringle, 1998; Witz, 1992)

Theoretical perspectives on medical work practice were initially developed without reference to gender even though, according to Game and Pringle (1983: 14) 'gender is fundamental to the way work is organised; and work is central in the social construction of gender'. Instead, the workplace was

structured to present a biased view of organisational functioning that favoured the work practices of men and did not acknowledge, or meet, the needs of women who carried the main responsibility for childcare and domestic tasks in the home (Davies, 1996; Witz, 1992). This organisational structure has shaped the beliefs and values that inform work practices in medicine where the interests of women doctors are less well served than those of their male colleagues. In such a climate, female medical practitioners have made huge efforts to work within this structure notwithstanding their commitments at home (Crompton & Le Feuvre, 2003).

Women's complicity with hegemonic expectations of gender relations suggests an inequitable power balance between men and women where women generally carry the domestic and childcare load on top of their work commitments. Women may accept this construction as conventional wisdom and not consider it exploitative, despite it serving the interests of their male partners. Bourdieu (2002: 73) suggests that their 'doxic' or 'uncontested acceptance of the daily lifeworld' misrecognises the symbolic violence being perpetrated against them. Women's doxic acceptance of their central role of caregiver continues to exert a significant influence on their working lives. Findings from research by Crompton and Le Feuvre (2003) carried out in Britain and France show women doctors still retain the major responsibility for childcare and domestic tasks with many choosing general practice because they have more control of their hours. Hakim (2003a) carried out a national research project in Britain on women's difficulties generally when they attempt to combine work and family life. Her findings showed that, in the absence of financial need, only five per cent of mothers would choose to work full-time, three quarters would prefer part-time employment and 20 per cent would prefer not to work at all. Mothers who work full-time said their parenting role was central to their lives until their children had grown up and left home. Very few women sought to change conventional wisdom regarding the central place of motherhood in their lives in relation to their work outside the home.

Conventional models of medical work practice illustrate patterns that meet dominant ideas of masculinity and femininity with male as provider and female as primary caregiver. Male rural GPs are often able to work long hours

because their wives/partners subjugate their own career aspirations and become the main home-maker in order to support the GP and his practice. Spouses of female rural GPs are more likely to fulfil the role of provider and work outside the home (Wise et al., 1996) while their GP partners work part-time. However, Pringle (1998) cautions against adopting a position where women doctors are seen as victims to a male dominated, medical culture rather than as successful agents for change. She argues that, by virtue of women highlighting the need to question current practices, and their increasing numbers in the medical profession, they are making a difference to the culture of medical work practice which is slowly being restructured. This suggests a dialectical relationship between structure and social practice as any tension caused by female medical practitioners resisting conventional work practices is opening the door to change.

### **The feminisation of the medical workforce**

Hegemonic expectations of rural medical work practice to work long hours cause tension when they conflict with the interests of female GPs to meet the demands of their roles at home. The dialectical relationship between structural issues and social practice is revealed when dominant ideas about gender practices are accepted by female GPs in one context and resisted in another. Tension arises because conventional expectations of a rural GP's work practices are incompatible with expectations of being the primary caregiver in the home. Change occurs when female medical practitioners may choose to work fewer hours in the workplace so they can meet expectations to be responsible for childcare and domestic tasks, thereby reproducing the dominant belief of women as the primary caregiver. However, their male colleagues are frustrated that they have to 'pick up the slack' when female GPs go home. Rather than considering the role of structural influences on social practice, male GPs often implied that the problem is the female GP not 'pulling her weight' in the workplace.

GPs who respond to the inter-personal nature of the issue may fail to address the problem at a structural level that has long reflected hegemonic ideas of gender relations and supported the work practices of male medical practitioners. Women medical practitioners have adapted to a male model of work practice that has demanded 'a vocational commitment [and] a readiness to

be available 24 hours a day, seven days a week' (Pringle, 1998: 2). They have also tried to meet their domestic and childcare responsibilities. Expectations to conform to a male work ethic in medical practice and meet the demands of home-maker are unjust particularly when women doctors may be treated as inferior by their male colleagues and not be considered 'real doctors' (Pringle, 1998: 10) if they unable fulfil the 'vocational commitment' (p.2) to their work.

While women medical practitioners may not be victims to their circumstances, a broader interpretation of the problem does reveal how power relations within the social structure inform ideas about 'normal' practice in gender relations in specific contexts (see Connell, 1987: 120). Hegemonic ideas that essentialise or reduce gender relations to a clearly defined division of labour based on male as provider and female as primary caregiver are not recognising the complexity of the issue nor addressing the effects of these beliefs across contexts. If female GPs are disparaged and treated as inferior for not conforming to hegemonic ideas of rural medical work practices, even though they are complying with dominant gender expectations in the home, this constitutes a form of symbolic violence.

According to Wainer (2004: 52), female GPs who carry the main responsibility for their children 'cannot be on-call for their practice and their family at the same time without support'. Yet in rural settings, childcare services are often limited. Therefore, in order to meet expectations of their role in the home, female medical practitioners are calling for flexible working hours. Effectively, they are acting as agents for change in the workplace while conforming to hegemonic expectations of the division of labour in the home. While their calls for change in the workplace are not new, they are becoming louder as women enter the medical profession in greater numbers. This development is having a significant impact on medical work patterns in Western industrialised countries (Lapeyre, 2003; Wainer, 2001), a trend that is expected to continue (Riska & Wegar, 1993).

Beagan (2001) used 1996 data from the Association of Canadian Medical Colleges to show that over 52 per cent of Canadian medical students were women. Similarly, Incitti, Rourke, Rourke and Kennard (2003) drew on figures

from the 1998 Canadian Medical Association Data file to show that the number of female physicians increased by 166 per cent from 1980 to 1995 compared to a 26 per cent increase in the number of men. More women are entering the medical profession in the United Kingdom (Elston, 1993) and in France, over 50 per cent of medical students are women (Lapeyre, 2003). In Australia, women now constitute nearly 60 per cent of students in medical schools (Australian Medical Workforce Advisory Committee, 2005). Numbers of female GPs have also been increasing from 23 per cent in 1984-1985 to 34 per cent in 2000 (Australian Government Department of Health and Ageing, 2005; Hirsch & Fredericks, 2001). Over 50 per cent of GPs under 35 years are female (Australian Government Department of Health and Ageing, 2005) and women make up 60 per cent of GP trainees (Australian Institute of Health and Welfare, 1999b). It is anticipated that by 2030, 60 per cent of medical practitioners will be women (Australian Medical Workforce Advisory Committee, 1998). In 2003, nearly 30 per cent of the rural GP population in Australia were women (Australian Medical Workforce Advisory Committee, 2005).

Women's entry into the workforce in the last 30 years and the increasing feminisation of the medical profession provide an 'excellent opportunity to change the nature of work and attitudes to it' (Hamilton, 2003: 171). Not surprisingly, resistance to change prevails among some sectors of the medical profession where medical discourses on work practice often subordinate the work of female medical practitioners to that of males because women often work fewer hours and therefore are seen as less committed. This response effectively deflects from addressing structural elements that reproduce dominant ideas and practices in a rural medical context. The organisational structure of medical work practice and the gendered division of labour in the home constrain and often belittle women's attempts to meet their dual roles. Pringle (1998: 158) argues that many male doctors think of women as a 'part-time subsidiary force, helpful in dealing with psychological problems, but not real doctors'. The 'part-time subsidiary force' is a sentiment reflected in the quote by the male GP at the beginning of this chapter.

Nonetheless, Pringle (1998) contends that women doctors who call for changes to the fundamental 'vocational' beliefs and work practices of medicine

as a profession to better meet the demands of home and family demonstrate their sense of agency. However, women's wish for change is often predicated on the gendered division of labour at home. As women reproduce dominant patterns of gender relations in one setting and act as agents of change in another, the ramifications of their 'doxic acceptance' (Bourdieu, 2004: 168) of the role as caregiver in the home are felt in the workplace.

The dialectical relationship between structure and social practice is illustrated as women experience tension in the struggle to meet their dual roles. The potential for change emerges from this tension. Female medical practitioners who choose to work fewer hours to meet the demands of home are precipitating calls for changes to work practices favouring long working hours. Thus, the effects on rural general practice of female GPs conforming to dominant gender expectations in the home is destabilising the organisational structure of patterns in the medical workplace. Women doctors are drawing attention to the relationship between the public and private spheres showing that the two contexts are linked (Pringle, 1998). Their calls for changes to work practices are transforming the image of medicine from an all-consuming vocation, where the needs of patients are often prioritised over those of family, to medicine as an occupation requiring less time at work and leaving more time available for personal and family commitments (Carson & Stringer, 1998; Pringle, 1998).

The tension caused by this change in perspective is slowly transforming ideas about medical work practices. Research shows a shift in attitudes in rural general practice in Australia towards increasing demands for shorter working hours, a reluctance to undertake on-call work, and a growing demand for locum relief (Australian Medical Workforce Advisory Committee, 2005; Rural Doctors' Association of Australia, 2003b; Wainer, 2002). This shift in expectations is reinforced by growing numbers of male rural GPs also preferring a better balance in work and home life (Carson & Stringer, 1998; Strasser et al., 1997). Studies suggest that increasing numbers of men want to share responsibility for childcare implying that caring for the home and family is a parental responsibility rather than a predominantly female task (Carson & Stringer, 1998; Clearihan, 1999). However, men's aspirations are not always realised in practice. Overall evidence in Australia on the gendered division of labour suggests that, notwithstanding

hopes to share parenting more equitably, most men prioritise work over family (Bittman et al., 2004). Their contribution to domestic tasks and childcare is often in the form of 'helping' their wives in the home and with the children only if it does not interfere with their paid work and leisure time (Dempsey, 1992).

In one study carried out on the Australian medical workforce, in which 296 medical practitioners were interviewed of whom 51 per cent were female, findings showed that 95 per cent of women interviewees carried the main load for childcare. Not surprisingly, the careers of male medical practitioners were less likely than those of their female colleagues to be influenced by family considerations (Australian Medical Workforce Advisory Committee, 1998). Such findings again demonstrate that different work practices required by many female medical practitioners to meet the demands of their role in the home are affecting work patterns at a structural level and questioning the ethos of medicine as a vocation.

Female rural GPs' calls for flexible working hours to make meeting the demands of home easier have led to a change in attitude in some of their male colleagues working in rural areas as they, too, seek a balance between work and home. At one level, this development evokes Gramsci's idea of alliances being formed where one group, male rural GPs, supports the interests of another group, female rural GPs, in a way that strengthens the challenge to hegemonic ideas influencing work practices. At another, women medical practitioners are acting as agents for change, in Bourdieu's sense, by transforming work practices rather than internalising objective realities that do not serve their interests. This supports Pringle's (1998) idea that a major shift is taking place and that female practitioners are instrumental in transforming medical work practices.

### **Balancing work and home**

Although women currently comprise only 30 per cent of the rural GPs in Australia (Australian Medical Workforce Advisory Committee, 2005), their growing numbers in the medical profession generally are strengthening calls for changes to the organisational structure of rural general practice. Women want medical work practices that better reflect and values their identities and needs as working women and mothers (Australian Medical Workforce Advisory

Committee, 1998; Crompton & Le Feuvre, 2003; Wainer et al., 2001). Yet, despite more women making up the cohorts of incoming rural GPs, their needs are not well represented in policies and programs for rural general practice (Wainer, 2004). In Victoria, 65 per cent of female rural GPs reported being the main caregiver for their children and worked the least clinical and non-clinical hours. Sixty three per cent worked part-time with 83 per cent of female rural GPs claiming it was for family reasons (Wainer, 2001). According to Wainer (2000), rural medicine needs a better organisational structure to meet the needs of female rural GPs in order to attract and retain their services. A study carried out in rural Queensland reiterated this theme where findings showed female GPs need greater flexibility in work practice to better balance the needs of family (White & Fergusson, 2001). In Western Australia, a similar study investigating the needs of female rural GPs recommended government support for initiatives to explore different models of practice that are 'flexible and sympathetic to the difficulties faced by female GPs' (Roach, 2002: 5).

Female medical practitioners have a vested interest in instituting more flexible work practices that allow for shorter working hours in order to meet their other responsibilities (Crompton & Le Feuvre, 2003). Nonetheless, some female GPs continue to adapt their lives to fit in with a model of rural practice that espouses the values, experience, training and professional development of male practitioners who influence the organisational structure of the profession where overwork is seen as a sign of dedication (Bryant, 1997). They are often faced with a struggle of wanting to meet the needs of their family yet not wanting to rock the boat at work, a seemingly no-win situation as they try to juggle the conflicting demands.

Nonetheless, female doctors who take more responsibility for childcare and domestic tasks than their male spouses/partners are, by default, undermining vocational attitudes in the medical workplace by being unavailable to work long hours. However, conforming to expectations of their role in the home has led to their subordination in the workplace. Responses labelling female rural GPs as 'fairy wrens' who 'flit in and out' (AMGP 6) imply that not conforming to dominant work practices is unacceptable and leads to diminished status. Such a response is unjust in that it fails to recognise or meet the interests of women and

constitutes a form of symbolic violence that is embedded in discourses minimising female doctors' role if they resist hegemonic work practices thereby reproducing their subordinate status.

However, research has also shown that female medical practitioners are reluctant to confront the patriarchal structure of the medical profession even though it diminishes their work practices and their efforts to strike a balance between work and home. Findings from studies on female doctors in Britain indicate that conforming to social expectations, rather than confronting and questioning them, was the norm. Female doctors made choices during their training about traditional gender roles where they assumed they would take responsibility for any future home and family, which they frequently did (Crompton & Le Feuvre, 2003). In France, many female GPs also led fairly conventional domestic lives with the male as the main breadwinner (Lapeyre, 2003). Beagan (2001) suggests that changes to the prevailing values underpinning medical work practice require more than increasing numbers of women entering the medical workforce. She argues for the need to recognise gender bias in medical training. In her study of Canadian medical students she found that a universal concept of 'the doctor' is still biased towards meeting the needs and interests of male rather than female doctors and is therefore not neutral. Male social dominance and privilege underpins this representation and ignores the fact that knowledge in this context, as well as all knowledge, is socially constructed and therefore not 'objective'. Until male GPs see their own biases, and female GPs their inclination to accommodate the status quo at an organisational level, change will be slow.

### **Gender and rural general practice**

However, changes are afoot. Clearly, calls for more flexible work patterns by female doctors are destabilising the traditional values underpinning medical work practice by raising awareness of the needs of female GPs to carry out their traditional roles at home (Pringle, 1998). Yet the dialectical relationship between structure and social practice is reflected in the struggle between two different approaches to work practices and between women meeting dominant social expectations in two separate contexts. This struggle has caused tension, not least

because greater numbers of women are practising medicine than in the past thereby adding strength to their demands to work more flexible hours. However, from this tension, change is emerging. Research from Britain supports the findings of Australian studies that growing numbers of male GPs prefer a better balance in work and home life (see Strasser et al., 1997). Young et al. (2001) agree that change is in the air and goes beyond younger male graduates wanting to work fewer hours, challenging the underlying vocational beliefs and practices of medicine as a profession. This shift in attitudes to work practice appears more widespread in Britain with many GP principals of all ages opting to leave general practice because of long hours and lack of balance between work and family. They, too, want more flexible arrangements that allow part-time work, job sharing and managed career breaks, suggesting a shift in priorities from medicine as a vocation to medicine as an occupation.

To illustrate the dialectical relationship between structure and social practice, I draw on interviews with male and female GPs in the next part of the chapter. Tension is evident in responses that reveal diverse approaches to work practices. Dominant ideas support a 'vocational' approach to medical work practice in a rural setting that involves long working hours. This expectation has been embedded in an organisational structure of power that subordinates practices that resist that norm. Responses in interviews show that some male GPs denigrate female colleagues' commitment to medicine if they work fewer hours. Such responses underscore the belief that 'real' medicine is about dedication, working long hours caring for patients that demands time away from home and family. This belief also presumes the presence of a spouse who cares for home and family while the GP is busy working. It fails to take into account those female GPs who trying to juggle the demands of the workplace on top of meeting expectations of their role as caregiver in the home, and, in the process, are changing the structure of medical work practices.

However, as Connell (1977) suggests, the relationship between dominance and subordination is never total; 'circles of resistance' (p.207) contest and weaken the power and control of dominant forces and change emerges as part of the counter-hegemonic process (p.220). Women medical practitioners choosing to work fewer hours to better balance both roles indicates a shift in

attitude to work patterns. While this shift may not be universally accepted within the rural GP workforce, it is not viewed disparagingly by all male rural GPs. Notwithstanding various discourses embedded within work practices that relate to dominant ideas of masculinity and femininity, responses from some male rural GPs support the findings of other studies as they welcome a less rigid approach to work practice and embrace the opportunity to work less.

Seven (46.6 per cent) of the 15 female GPs working in the Division, agreed to be interviewed on their expectations and experiences of rural general practice and how they meet the demands of home and work. Participants include those trained in Australia and overseas. All were in committed personal relationships. Interviews lasted between 20 minutes and two and a half hours and some participants agreed to be interviewed more than once. They ranged in age from early 30s to late 50s. Responses from several of the 25 male GPs whom I interviewed contribute to the discussion on changes to work patterns in a rural general practice setting. I begin by locating female rural GPs' experiences of their work in a wider social context to illustrate factors attracting them to rural general practice, influencing their decision to remain, examining the extent to which political and economic factors are affecting their enjoyment of their work and exploring their ideas on the future of rural health care.

### ***Female GPs' experience of changes to rural general practice***

In light of political and economic changes, female rural GPs face constraints on their work practices similar to those of their male colleagues. Demands for increased accountability in the medical workplace have led to feelings of apprehension and the need to 'over-investigate and over treat [patients] because you can't risk not doing it' (AFGP1) for fear of being sued:

People here sue for everything. ... It makes you practise defensive medicine so you order more tests, do more things that are probably totally unnecessary and add to the whole cost of everything (OFGP2).

Increasing government intervention in clinical practice is a 'constant pressure' (AFGP2) and having to meet administrative requirements is 'time consuming' (OFGP2) and leads to general practice becoming 'less satisfying' (AFGP2).

Nevertheless, rural general practice is still seen as preferable to working in the city because of the continuity in the care of patients, the diversity of the work and actively contributing to the community:

This is my life. This is everything I ever wanted. This is part of a ten year plan. ... I just want to stay here. I deliver babies and in 20 years time I want to be delivering their children (AFGP4).

Other factors attracting women to rural general practice have included financial incentives and good accommodation, especially for those working as solo GPs where they can come home at the end of the day without worrying about:

... the bloody mud in the back yard and throughout the house and where am I going to put my child's clothes when there is no hanging rail in the wardrobe and the tiles in the bathroom where the kids fall over because the bloody tiling is so bad. Things like that (AFGP1).

Female rural GPs also acknowledged the difficulties recruiting and retaining rural GPs although their solutions to the problem fell within a medico-centric paradigm. 'Training more doctors for rural general practice' was seen as the best option as 'Western Australia doesn't produce enough doctors to service its needs' (AFGP4). Another GP agreed with this idea for different reasons that reflected the effect of changes to work practices:

There are going to have to be more medical school places because [rural GPs] are not going to want to work all the time (AFGP5).

The idea of training more doctors was more popular than allocating Medicare provider numbers according to geographic location which was considered 'restrictive' and 'would really stop doctors going to the country' (AFGP4). The increasing use of nurse practitioners as another solution to the rural health problem, while acceptable to some female GPs who thought sharing the load was 'great' (OFGP2), was seen as problematic by others:

The government can't think that a [nurse practitioner] is replacing a GP because they are not. We have had six years of medical school plus another six years of training, plus more. Not that a nurse couldn't do it. She could do it if she went back and did it. Maybe a salaried doctor would be better (AFGP4).

Another GP had not 'viewed [senior nurses] as opposition or competition', instead feeling 'a great sisterhood with female nurses', but argued that the doctor had ultimate responsibility for patient care:

Nurses don't want to bear responsibility for the consequences. I had a phone call in the middle of the night to say a patient was deteriorating. I asked [the nurse] if she wanted me to come [and see the patient]. She replied: "oh no, I just have to tell you about it". So, if anything goes wrong it is my fault, not my fault, but my responsibility. I couldn't believe it. There are some areas where [nurses] want to do everything a doctor does but they don't want to cop the flack if things go wrong (AFGP5).

These responses highlight the central role medical practitioners have played in rural health care which is again being contested as nurses become increasingly skilled and experienced and compete for services once offered only by the medical profession. However, such responses also raise the issue of ultimate responsibility and indemnity in health care for nurses as they seek to expand their role in rural health care. The downsizing of rural hospitals in smaller rural centres as a result of economic restructuring and development is another reform confronting GPs. As a result, GPs have limited opportunities to practise procedural medicine outside large and medium rural centres. This has contributed to rural general practice in smaller locations being considered even less attractive:

Funding cuts to small hospitals and not allowing minor surgery to be done will reduce the desire for doctors to work in rural general practice because there is less to do. ... Essentially they become a city GP doing day to day work in a very small town. They have none of the advantages of being a GP living in a regional centre (AFGP4).

Despite five out of seven female GPs working full-time, most considered their role as home-maker and/or being responsible for childcare as an important part of their identity as a woman.

### ***Gender relations in the rural medical workplace***

However, while 'gender is not self evident as an issue for the dominant culture' (Wainer, 2003: 75), it was implicit in the responses of male GPs.

Evidence from responses of female rural GPs showed that ‘gender is ‘fundamental to the way work is organised; and work is central in the social construction of gender’ (Game & Pringle, 1983: 14). A constraining factor for female GPs working in rural areas, that was less evident in the responses of their male colleagues, was concern about employment opportunities for their husbands/partners. One GP said, she would not have considered moving to a rural area had she had realised her husband’s difficulty in finding a job. Another female GP linked the importance of meeting spouses’ needs, which intersected with dominant expectations of gender relations, when considering issues related to recruitment and retention:

So if you want people to come to the country we have to make it OK for the spouses. The only reason my associates can work [long hours] is because their wives do everything. Their wives can’t work because to look after someone working that many hours you have to be able to make a home (AFGP4).

Spouses’ responses to this idea are discussed in Chapter 8.

The idea of medicine as a vocation has long been underpinned by gender relations where male work practices involving long hours are considered the norm and work practices of female medical practitioners wanting to work fewer hours, are subordinated to those of their male colleagues. Changes to dominant work patterns have been slow to filter through at the level of organisational structure in rural general practice. In the home, conventional gender roles with male as provider and female as primary caregiver are reproduced in many medical marriages/partnerships. This has created a dilemma for female rural GPs where expectations to meet their role as a GP intersect with expectations of their role as spouse/caregiver in the home. Their attempt to balance their roles often causes tension in the workplace in relationships with their male GP colleagues.

Rather than address inflexibility within the institutional structure to better meet the needs of working women with children, responses of rural male GPs in interviews tend to focus on the detrimental effects to themselves of female rural GPs working part-time. They showed little recognition appreciation of the added workload at home for their female colleagues. Instead, female GPs who worked part-time were more likely to be disparaged for not taking their professional role

seriously enough—‘(flitting) in and out like fairy wrens’. There was a sense of resentment amongst some rural male GPs that their female colleagues did not adequately share the workload like ‘real doctors’, because of the hours they worked, with the implication that most female GPs ‘have it easy’. In fact, there was a suggestion that, by working part-time, female rural GPs added to the workload of their male colleagues because they are ‘never there when you need them’ (AMGP6), resulting in male GPs working longer hours:

I very much support the feminisation of the workforce but if that means I have to work longer and harder, and it does look like it, then I will be putting pressure on those women to work more (AMGP5).

Male rural GPs often assume that their female colleagues, rather than the spouses of their female colleagues, would take time off to look after their children. The lack of consideration for female GPs’ domestic workload on their availability for work reveals the prevalence of hegemonic gender practices in the rural medical workplace that laud those available to work 24 hours a day. This evokes Pringle’s (1998: 10) notion that such work patterns are part of the ‘medical sublime’ that gives the profession a ‘priestly’ dimension. Medical practitioners expecting to do less are not ‘real doctors’ and are not being ‘serious about their career’. Such responses imply a form of symbolic violence where female rural GPs’ work practices are denigrated unless they conform to hegemonic expectations, despite also carrying the load of home-maker with responsibility for childcare.

### ***Female rural GPs’ responses to hegemonic practices***

Rather than challenge the inequity of institutional structures that expect women, not men, to work a ‘double shift’ when they go home, most female rural GPs adapt by meeting the demands of both roles as best they can, notwithstanding the negative responses of their rural male colleagues. One female GP working part-time reflected that rural general practice was still very ‘male’ in its attitudes to work practices and commented angrily on her experience of male colleagues’ perceptions of female GPs:

I was only a pretend doctor because I was only working limited hours a week and the government wasted all this money training you, so that you could just go out and have babies (AFGP5).

Some male GPs reflect these perceptions, commenting that increasing the ratio of female to male doctors was ‘completely wrong’ (OMGP10). It would constitute ‘a very big problem’ (OMGP13) that would have a ‘severe impact in rural areas’ (OMG10) because male GPs would be left to ‘carry the can’ (OMGP5). None mentioned the effect on female GPs of fulfilling the demands of their dual roles in the workplace and the home nor the inadequacy of the organisational work structure of medicine to effectively meet the needs of working women with children. One male rural GP reflected, somewhat bitterly:

If there are 20 GPs here and ten of them are women, the ten men will still have to do the workload if the women won’t (AMGP5).

Interestingly, another female GP concurred with her male colleagues regarding the negative effects on male GPs of women working part-time. She commented on the ‘huge impact’ of the increasing feminisation of medicine on the future rural medical workforce by drawing on notions of medicine that support male work practices:

It’s different for female GPs. We have children, we get married and we don’t always work full-time. So the amount of money it costs to train a [female] doctor is not always that worthwhile (OFGP2).

Such attitudes reproduce hegemonic beliefs about the gendered division of labour in the home. Once her partner found full-time employment, this GP dropped her hours to work part-time. British research found that the majority of women in dual income families saw their financial contribution as secondary to that of their male partner (Hakim, 2003b). More specifically, other research has shown that female doctors generally fell into the role of caregiver in the home where their male partner was the main provider (Crompton & Le Feuvre, 2003; Lapeyre, 2003). Another female GP who was interviewed reacted defensively to feminist claims that women doctors have been forced to comply with male patterns of

work practice. She argued that the issue was not related to gender but to commitment and enthusiasm:

I get upset about people doing surveys saying female GPs in the country have a hard time. There is a lot of feminist stuff we get set sent [with questions like] do the male doctors put pressure on you to work longer hours; do you feel this interferes with your life with your children? It is not whether you are male or female, it is more whether you have this passion and you want to work (AFGP4).

However, her later comments reiterated the centrality of gender in rural general practice and the cost to women doctors of finding a suitable solution:

Not many women do obstetrics because it ruins your home life. Not many females want to do it because there is this need to want to have children and you can't do both. It's hard to do both. A lot of my friends who are female GPs choose to work far less hours (AFGP4).

Historically, rural general practice has been predicated on the assumption of male doctors being married (Wainer, 2001), where childcare and domestic tasks are generally divided along conventional gender lines with their female spouse responsible for childcare and domestic tasks. Some male rural GPs commented in interviews on the importance of having a 'good, understanding wife' (OMGP2) to support them. According to one, this was enough to fulfil the needs of some of their spouses:

We just work, we are happy to work, our wives accept the role we play in the community and the fact that we work hard. Some protest and others don't. Some are happy because they see their spouse is fulfilled in their role and they are probably happy in it themselves (AMGP1).

These comments not only reflect hegemonic expectations about the caregiving role of female spouses, but also imply that this role is sufficient to meet their needs. In this case, roles are clearly delineated into male as provider and female as primary caregiver. Role definition for female GPs who are also spouses is more ambiguous. Multiple femininities operate as female GPs struggle to meet the demands of different roles which often causes tension.

### ***Multiple femininities of rural female GPs***

One full-time, female rural GP decided to embrace conventional expectations of rural general practice by working long hours and relished the experience. She and her partner had decided not to have children. She conceded that the demands of her work made it essential to have a partner who was fully supportive:

This is my life. This is everything I ever wanted ... (Medicine) is a vocation and a passion ... The main reason I can work (full-time) is because my husband looks after me. I wouldn't be able to do this if I didn't have him. He does everything, cooking, grocery shopping, pays all the bills. He works [outside the home] three half days a week. The rest of the time he runs my business, his business, our home and we have chosen not to have any children. If I didn't have him doing that, I couldn't do (what I do) (AFGP4).

Without a supportive partner prepared to take on the load of domestic responsibility, maintaining this level of commitment to their work is difficult for female GPs. Most interviews revealed that many struggled to balance work and family life particularly if they had dependent children. Central to their sense of identity was their role as a mother which was compromised when they worked full-time:

I have always been very involved with the children and I couldn't do everything any more [when working full-time] (OFGP2).

This response showed this GP's strong inclination to spend more time with family rather than less, conceding that 'it is very hard mixing career and children'. One part-time female GP stated that 'medicine is not my life, family is.' Indeed, she went on to say that the female GP's role as spouse/partner and mother is fundamental to her identity:

For women doctors, what they do is not part of their core identity. Most women doctors would say their core identity was as wife and mother and GP would be third (AFGP5).

According to this response, female GPs are reproducing hegemonic patterns of gender relations in a domestic context which is effectively challenging dominant

ideas of work practices in rural general practice. Female rural GPs seek changes to their work practices in order to accommodate their responsibilities as main caregiver in the home. It is the desire to spend more time with the family that is motivating them to instigate changes at work to better meet their needs rather than wanting to transform the organisational structure of medical work practice, even though this is occurring as an effect of their actions.

From a structural perspective, female GPs are faced with a dilemma. They are expected to be caregivers in the home yet, if they want to be considered 'real doctors' (Pringle, 1998: 10), they need to 'be available' to work long hours (AMGP6). This often creates tension as they struggle to fulfil their dual roles. One full-time female GP with dependent children who had reversed roles with her partner indicated the importance of her role as a wife and mother:

My job is an important part of me as a person but it is not more important than my family life (AFGP1).

Another full-time GP commented that reversing roles with her male partner in theory did not always link to practice in terms of a fair distribution of childcare and domestic tasks. She found that the 'problem' of 'sort[ing] out the children' (AFGP2) was still relegated to the woman in addition to her professional workload. Indeed, the poignant, and destructive, effects of supporting hegemonic beliefs are illustrated in their impact on this GP's sense of wellbeing:

Another challenge is balancing work and family in a way that you don't burn out and part of that is not wanting to be a hero. But, interestingly, I don't mind if my husband, children or I suffer, but if the patients suffer because I am burnt out I have to stop (AFGP2).

Clearly, expectations of gender roles in the home play a significant role in the work practices of most female rural GPs, often revealing the tension that exists in the relationship between the public and private spheres when one intersects with the other (see Pringle, 1998). Female GPs struggle 'with the profession, with husbands, and with forces deep within themselves', to resolve seemingly 'overwhelming contradictions in their lives' (Pringle, 1998: 159) when expectations persist about heroic notions of rural general practice and women as caregiver in the home. Providing solutions such as increasing

childcare facilities, does not effect change at a deeper, structural level, but helps female GPs adapt to the current, gendered division of labour at home and in the workplace thereby reproducing dominant work patterns where the role of female GPs in the workplace is subordinated to that of their male colleagues.

However, ‘circles of resistance’ (Connell, 1977: 207) to hegemonic views are occurring in the workplace as a result of social changes. One part-time, female GP in her 40s acknowledged that:

Women are less likely to be pushed into working a lot because we don’t buy this ‘we are just playing, pretending to be doctors,’ especially these days, when women have to pay their own uni education and are just entitled to get what they want (AFGP5).

Nonetheless, this did not stop the tension that emerged from trying to balance parenting and work roles, illustrated in the responses of one female GP:

My daughter felt that I wasn’t there for her when she was growing up because I was always working. I feel guilty about that but juggled work and family as best I could (AFGP2).

Despite the fact that the majority of female GPs whom I interviewed worked full-time, some rural male GPs considered that female doctors generally work part-time. Such attitudes reproduce the notion that women are more likely to work fewer hours because of family commitments, which effectively diminish their professional status. Few male rural GPs showed compassion for their female colleagues juggling their various roles. Some older male GPs rationalised female GPs working part-time with essentialist views of gender roles showing little understanding of the structural constraints experienced by many women in their role as a rural GP. Instead, male rural GPs’ legitimated the choice of their female colleagues to spend more time in the home by viewing women as ‘more compassionate and nurturing’ and wanting to ‘have babies’ as part of the ‘mother instinct’ (OMGP10) reinforcing their role as carers and nurturers. Few rural GPs critically examined essentialist notions of gender relations underpinning parenting roles or the distribution of domestic chores.

Some female rural GPs blamed themselves for their perceived inadequacies in parenting, rather than the institutional structures that perpetrate a

form of symbolic violence against women. Practices sanctioning a heroic dedication to work and the inequitable division of labour in the home where women carry the heavier load of parenting and domestic tasks are unjust. They create a double burden for most female GPs who work a 'second shift' making it more difficult to achieve a balance between work and home. According to one part-time female GP, balance is required for optimum wellbeing:

To be the best doctor you have to have a balanced life. You have to take your own advice and eat well and exercise so that less doctors will be coerced into being the Lone Ranger in the middle of nowhere doing it all ... It is just not possible to expect the doctor to be on-call 24/7 any more (AFGP5).

The demands of female GPs towards more flexible working hours are being echoed in the responses of some of their male colleagues who were mainly in their 30s and 40s. This group of rural male GPs saw the benefits of balancing the demands of work and home. However, they experienced resistance from other male GPs who conformed to work practices espousing the vocational nature of rural general practice. One older female GP who had internalised the conventional model of rural general practice as a vocation bemoaned the demise of the dominant work ethic in younger GPs who now consider 'lifestyle is more important than the job' (AFGP3).

### ***Multiple masculinities of rural male GPs***

One male GP commented on the 'huge expectations' (AMGP10) in the 1980s for male GPs to work long hours and take no part in childrearing at all. He wanted to work part-time when he was younger so his wife could also work and he could spend more time with family. He commented that this choice was considered an anomaly and viewed disparagingly by his colleagues. Hegemonic expectations about gender roles were evident in responses indicating that male rural GPs work full-time and do on-call work while female rural GPs are able to work part-time because of their family responsibilities. Twenty years later, male GPs wanting to work less was becoming more acceptable, at least in theory.

Calls by female rural GPs for more flexible working hours are beginning to have a ripple effect within the profession as they are echoed by some male colleagues. Some younger, male medical graduates are now making 'lifestyle'

rather than vocational choices that focus more on the balance between work and home. Two male GPs in their 30s also commented on the importance of having a 'happy family' (AMGP3) by working fewer hours. One worked 'semi-part-time ... to spend more time with [my family]' (AMGP3) with another commenting that 'my career is second to my family' (AMGP12). He further stated that his younger male colleagues were 'more into self preservation' by choosing to work less:

There has been a cultural shift. There is a lot more awareness about what is necessary to function well and a lot more political lobbying. ... It is not really acceptable to do the long hours and there is a reticence in doctors to want to do that now (AMGP12).

One full-time female GP noted the wisdom of this shift:

Younger male graduates also want less time at work... I honestly do think you are a better doctor if you have a balance [between work and home]. It is not normal to work as a doctor 24 hours a day seven days a week. It is not a life. It is not good for your children or your family life (OFGP2).

One couple in their 40s both decided to work part-time to 'free us up to do a lot more things together'. Neither espoused to an 'heroic' attitude of rural general practice:

I have met enough doctors who thrive on stress and deliberately choose to work in practices that would kill Annette very quickly (AMSP2).

Nevertheless, one GP who had opted to avoid stress by reducing the number of patients he saw every hour, commented that rural general practice was still:

... a culture of high achievement and working hard. Not a place for slackers but for 'A' grade personalities (AMGP2).

This sentiment was reflected in the comments of one spouse of a younger male GP discussing expectations in some rural general practices where GPs were 'workaholics' and private practice was about 'getting your head around time is money and having to make money for the practice' (AFSP2). One older male GP had conformed to the vocational work ethic for many years and became ill. He subsequently took off several months from work, and reflected on his

experiences and choices, gaining insight into the effects of 'a culture of high achievement and working hard' on his health and wellbeing. As a result, he actively worked towards achieving a balance between his work and home life:

I never expected my family to cope when I (was) at work (if) they (had) some serious problem. ... There were probably times when I should have been with them and I wasn't. I think I have learnt that I shouldn't ignore them. They are more important than my patients. My patients can always see someone else. ... Whereas my family have always ... had a lower priority than everyone else. I have tried to change that. The family were taking too low a priority. I think the generation x-ers will get it right...I have to respect their attitude towards work. It is much more balanced but I am not sure where all the doctors are going to come from ... (Our generation) works like crazy and the generation x-ers decline doing that. It makes so much more sense (AMGP6).

### **The future of rural general practice**

The increasing feminisation of the medical workforce has widened the lens through which to view and understand medical work practice. The dialectical relationship between structure and social practice is evident as female rural GPs challenge dominant work patterns espoused by many of their male colleagues often causing tension as women struggle to meet their dual roles. From this tension has emerged the idea that the organisation of medical work practices does not derive from a commitment to an 'heroic' vocational ideology; rather, it is shaped by changing social relations in which gender is a key factor. Thus, when increased numbers of women enter the medical workforce, they bring with them the social expectation and aspiration that as women, they will assume domestic responsibilities, especially care for family members. This has translated into increasing demands by women in medicine for greater flexibility in their working hours to accommodate the demands of home and work.

The responses of several female rural GPs who were interviewed for this project reflect the tension these demands generate as they conflict with the dominant mode of rural general practice that is strongly underpinned by a belief in medicine as a vocation where dedication to the job is reflected in long working hours. Yet it is difficult for female GPs to subscribe to this ethic and practice and also to be the main caregiver at home without becoming over-burdened. In

response, female GPs are opting for a different approach to work practice that permits them to incorporate their household and family responsibilities. This shift is contributing to a change in perspective from medicine as a vocation to medicine as an occupation, where fewer working hours allow more time to meet other needs.

The desire for changes to work practice for some rural female GPs is underpinned by gendered imperatives associated with women's assumption of caregiving and domestic responsibilities. It is the effect on work practice of these imperatives that is calling into question the organisational structure of rural general practice. Such change is clearly associated with the markedly increased numbers of women entering the medical workforce. This has led to a shift in priorities from medicine as a vocation to medicine as an occupation, an idea also reflected in the career aspirations of some young male graduates who are prioritising a 'balanced lifestyle' over medicine as a vocation by choosing to work fewer hours. Some older male GPs are also seeing the benefits of a balance between work and home.

Nevertheless, there remain pockets of resistance to this development within the rurally based medical profession who continue to work according to the demands of traditional medical work organisation and practice. Not surprisingly they experience overwork but often attribute it to female GPs rejecting full-time work arrangements. Few male GPs in this category critically examine their sense of entitlement that female GPs should share the load at work more equally and not leave 'when there is a rush on' (AMGP 6). When female GPs do leave work early to attend to the family, male GPs often feel frustrated that they are left 'holding the baby' at work. There appears to be little reflection on the inequity in the gendered division of labour where the woman carries the lion's share of the load in the home, a significant factor in her desire to work more flexible hours.

Transposing Beagan's (2001) idea of bias in the context of gender relations to a domestic setting throws light on the fact that, until male GPs see their own biases in gendered division of labour in the home, and female GPs their inclination to accommodate conventional gender practices, change will be

slow. Such responses maintain the prevalence of current practices that reinforce hegemonic approaches to the gendered division of labour at home and at work in a rural context. Given the increasing feminisation of the medical workforce, the efficacy of maintaining practices that subordinate the needs of women GPs warrants serious consideration in light of future strategies to recruit and retain doctors in rural general practice. Gendered imperatives associated with women's assumption of caregiving and domestic responsibilities is also a theme in the expectations and experiences of spouses of rural GPs, a topic which is investigated in the next chapter.

## CHAPTER 8

### On being a 'good' spouse to a rural GP

Bernard (1982) argues that there are two marriages<sup>28</sup> in every union - his and hers. The needs of both parties compete in a relational context though female spouses generally subordinate their needs to those of their male partners, reflecting the deep seated gender beliefs in Western culture where men's work and needs are more highly valued than women's (Bernard, 1982; Delphy & Leonard, 1992; Summers, 2003). Finch (1983) argues that when a woman marries, she marries not only the man but the man's job around which her life then revolves. This idea draws attention to Pringle's (1998) notion of the overlap between work and family that reflects the relationship between public and private spheres, an idea which is particularly relevant in the context of the committed relationships between rural GPs and their spouses. The structure and organisation of men's work often constrains the choices of women, particularly if they are financially dependent on their spouses and are expected to fit in with the demands of their husband's occupation (Finch, 1983). It is wives who generally make career sacrifices to support their husband's career over their own (Yalom, 2001).

In 1971, few women in Oakley's (1985) study questioned their role as caregiver in the home which was considered primarily the woman's domain although her husband may have 'helped' (p.159). Seventy per cent of women interviewed in her study were dissatisfied with housework, citing monotony, fragmentation and loneliness as frequent complaints, yet few disputed their primary responsibility for childcare and domestic tasks. Other more recent studies reveal the conservative orientation of many women in committed relationships who comply with hegemonic ideas in the allocation of gender roles with male as main breadwinner and female as responsible for childcare and domestic tasks (Crompton & Le Feuvre, 2003; Dempsey, 1997a; Hakim, 2003b).

---

<sup>28</sup> In this chapter, I use the notion of marriage interchangeably with that of a committed relationship between a man and a woman.

These findings are reflected in responses from interviews with the female spouses of rural GPs in this study. Instead of acting as agents for change to their subordinate status, most women made choices that reproduced dominant ideas of gender relations.

While the needs of medical practitioners have been the main focus of research on recruitment and retention, rural general practice also affects the GP's spouse, whose needs therefore also warrant consideration. Most rural GPs in Australia are male with economically dependent spouses (Australian Government Department of Health and Ageing, 2005; Nichols, 1997). Wise et al (1996), in their study on the extent to which being a rural doctor's spouse in Australia determined their occupation, found that the role of female spouses, who were the majority, was closely connected to supporting their partner, the practice and its patients which often led to their own professional or educational interests being subjugated. The study showed that female spouses' lives and activities revolved around their partners' medical practice far more than the lives of spouses of urban GPs. Male spouses of female rural GPs were more likely to be employed full-time earning an income outside the practice and to be working in their original professions.

This chapter identifies how hegemonic ideas about gender relations in rural medical marriages/partnerships are reproduced and contested. Gramsci's notion that hegemonic beliefs direct social consciousness can be applied in this context. This idea has been effectively developed in Connell's (1987; 1995; 2002) body of work on the social practice of gender. Connell (2002) argues that gender relations do not exist outside the social structure which endures because gender relations are reconstituted in social practice. A consensual reality is formed when subordinate groups, in this case women, agree with dominant ideas, values and beliefs about masculinity and femininity and the gendered division of labour and accept them as the norm or common sense.

When dominant beliefs and ideas are resisted at the level of practice the dialectical relationship between structural elements and social practice is revealed. Tension arising from opposing ideas provides space for 'new meanings [to] emerge' (Pringle, 1997: 79) where women who resist hegemonic

expectations of their gender role act as agents for change. In this light, they contribute to a plurality of femininities within the social practice of gender indicating that the dominance of one group over another is never total (Connell, 1977).

However, Pringle (1997) suggests that the community generally perceives notions of family as more authentic when they conform to essentialist views of being 'natural' or biological, as opposed to seeing the family as a social construction. Essentialist views of family have held sway in rural communities in Australia, a theme expanded later. Previous research has shown that female spouses of medical practitioners often conform to conventional gender roles in marriage and demonstrate less interest in pursuing paid work or study outside the home, unless it is related to their partner's general practice (Fowlkes, 1980: 29; Wise et al., 1996). Distance from the metropolitan centre, limited opportunities to work in their chosen profession, and a desire to be the main caregiver and support their partners' work are some factors shaping female spouses' complicity.

However, conformity to their prescribed role is occasionally resisted. Responses indicate frustration in some rural GPs' spouses at the constraints social expectations impose on their choices and sense of identity. Nonetheless, most spouses complied with such expectations and subjugated their own educational and occupational aspirations or adapted them around the needs of their family. Few discussed the possibility of their GP partners modifying their work practices and leisure pursuits to enable spouses to fulfil their own aspirations. Responses from male spouses revealed that they all worked or were seeking work. Those who were employed, including two had reversed roles and were the main caregiver, were working in their chosen field.

The link between structural factors and social practice in a medical marriage/partnership is significant in the questions it raises regarding recruitment and retention. As increasing numbers of women participate in the workforce, can we assume that female spouses of rural GPs will want to give up their careers in future to follow those of their partners? Given the reputed interest of fathers' involvement in parenting, are male GPs and male spouses of female GPs,

prepared to change their work practices to accommodate the career or educational aspirations of their spouses? To what extent would modifying the organisational structure of general practice address some of the problems of recruiting and retaining GPs?

The first part of the chapter locates rural medical marriages within a wider context of gender relations. It presents research that offers a backdrop to gender relations in marriage, medical marriages and marriages in a rural setting to illustrate the dialectical relationship between structure and social practice. This is followed by an analysis of ethnographic information that examines the expectations and experiences of spouses of rural GPs in response to their prescribed gender roles and their decision to remain in, or leave, rural general practice.

### **Hegemonic gender relations in marriage**

One reason dominant ideas of gender relations are reproduced is the persistence of influential cultural stereotypes about what constitutes a 'good' wife where 'the subservient female [is] dedicated to the satisfaction of her husband's needs' (Oakley, 1985: 157) over and above her own. Hakim's (1995; 2003a) more recent studies in Britain revealed that one third of women experienced home and childcare as their main focus in life and believed that women should not combine a career with a family. Two thirds of women agreed that a job was necessary to gain independence though many saw themselves, not as career women, but as contributing to the household income. They worked outside the home partly because of current instability in the job market where their paid employment was considered an 'unfortunate financial necessity' (Hakim, 2003a: 52) taking them away from their central role in the home. Across Europe, women continue to be 'heavily dependent' (Hakim, 2003b: 50) economically on their male partners. De Vaus' (1997: 6) analysis of findings from the 1989-90 National Social Science Survey and the 1995 Australian Family Values Survey show that 75 per cent of respondents supported the role of women as the main caregivers in the home and men as breadwinners and protectors of their families. It is this conservative belief system that shapes the role of many spouses of rural GPs. Yet, women continue to receive mixed

messages. They are offered conditional support in wanting independence and pursuing a career, but only if it does not interfere with their main role as caregiver.

The capacity of men to work full-time as the provider is facilitated by the dominant ideas of gender relations being reproduced. Dempsey's (1997b; 1999) research on women's perceptions of fairness about who did the housework revealed the belief that men's employment outside the home was seen as more important than women's. Most middle-class women considered allocating housework to women as fair and supported the idea that men were entitled to relief from housework if they earned more than their spouses. According to Dempsey (1999), even women with a higher occupational status than their spouses, and who contributed more financial resources than men to the family income, did not use these resources as a reason to change the division of labour in the marital relationship. Instead they remained responsible for the bulk of domestic tasks in a way that hid differences in occupational status in order not to threaten the traditional power base of the male spouse. A study in the United Kingdom on professional women contributing to household income reported similar findings and showed that many women feel guilty if they are not 'totally devoted to their home and caring responsibilities' (Benjamin, 1998: 777) and seldom use their financial independence as a power resource in their relationship. In these contexts, women place greater value on their spouse's role as breadwinner that is complemented by their role as caregiver, perpetuating their subordinate status and reproducing hegemonic gender relations. According to Tichenor (1999), rather than thinking this arrangement unfair, many women judged their success as wives and mothers in relation to how much work they did around the house, rather than the status of their job and how much they contributed to the family coffer.

Feminist challenges have revealed prevailing inequities in the division of labour in the home but appear to have done little to diminish pervasive attitudes and practices that relieve men from contributing equitably to childcare and domestic chores. In fact, women who want change, but are unable to effect it, are more likely to reframe what they had previously considered unacceptable as acceptable. One of the reasons for this response is to avoid contention within the

relationship for the greater goal of maintaining a harmonious marriage (Dempsey, 1997b; Hochschild, 2003). Increasing numbers of women entering the paid workforce take on the domestic load and childcare on top of their paid employment while their husbands are often relieved of such responsibilities (Bittman et al., 2004; Dempsey, 1997a; Hochschild, 1989). Brines (1994) suggests that the gendered division of domestic labour is less about who earns the bigger share of income and more about a way to symbolically conform to conventional practices regarding dominant views on what constitutes femininity and masculinity. Indeed, rather than supporting feminist challenges to the inequitable gendered division of labour, many women continue to make choices that reproduce current practices notwithstanding some who are their dissatisfied with the inequity of existing arrangements (Bernard, 1982; Dempsey, 1997a; Finch, 1983).

Such practices suggest women's doxic complicity with their subordination. They accept responsibility for childcare and domestic tasks, often in addition to working outside the home, rather than challenging the inequity of conventional wisdom in gender relations. Their 'uncontested acceptance' (Bourdieu & Wacquant, 2002: 73) of this so-called norm implies that women may misrecognise the symbolic violence being perpetrated and accept as axiomatic men's dominance even though their needs outside their caregiving role are considered less important or are not valued with women displaying less sense of entitlement to demand resources or meet their aspirations. Such beliefs and practices imply that, in accepting 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 2002: 167), many women may not acknowledge and therefore may not seek to change the situation by challenging their subordinate position. At another level, women's reluctance to contest conventional wisdom relates to what they may stand to lose if they do not conform.

Women's disinclination to challenge dominant ideas about gender relations is shaped by a lack of social acceptance of their role as breadwinners and men as the main caregivers (Hand & Lewis, 2002). Indeed there is limited support for role reversal at the level of social practice in Australia where '[a]nything which smacks of the 'feminisation' of men is likely to evoke the

image of wimp; clearly, the domesticated New Age man is steering dangerously close to femininity' (McMahon, 1998: 150). While Finch (1983) has argued that wives' domestic and childcare responsibilities constrain their opportunities to work, Hakim (2003b: 257-258) suggests that women 'are just as able as men and can perform equally competently in any occupation ... yet personally choose to be full-time home-makers or secondary earners who give priority to their families'. Their sense of indebtedness to their spouses as providers leads many to feel gratitude rather than resentment (Lennon and Rosenfield 1994 cited in Dempsey, 1999: 6). Such a view highlights the power of structural forces in influencing social practice. Women's choice to conform may well be linked to their wish to avoid conflict and secure a good family life and future for their children (Dempsey, 1997b), particularly if they are economically dependent on their partner.

Unpacking this idea to reveal a more complex, nuanced understanding is also warranted. It is important to acknowledge what women stand to lose if they do not conform to hegemonic expectations of their role. In the context of rural general practice, female spouses who are not employed, and/or who choose not to continue their education or training and who are dependent financially on their GP partners, run the risk of losing their professional or occupational skills that may jeopardise their employment prospects should their circumstances change. According to Baxter and Western (1998), women with fewer resources stand to lose more if the marital relationship is disrupted because of the constraints on their options. Dempsey (1999) suggests that when women gain more economic power their sense of gratitude lessens and their sense of entitlement increases and they are more likely to perceive injustice in the division of labour. However, women who have fulfilled their role as the primary caregiver in the marriage and have not worked outside the home, yet are dissatisfied and unhappy, have limited choices and are often unable to leave their relationships without significant socio-economic hardship (Connell, 1987). If they do leave, Tavris (1992) argues that their standard of living drops while that of their husbands' often rises considerably, so women are clearly more disadvantaged not only economically but also socially and psychologically (Steil, 1997).

For most women, 'the contrast between the standard of living that they enjoy while married and that which they can expect after divorce simply redoubles the pressures in favour of marriage' (Delphy, 1992: 139). What is evident is that many women err on the side of caution rather than revolution when it comes to challenging the prevailing gender culture within marriage. It seems that, rather than inequities in the division of labour creating an impetus for social change, women often make choices that reinforce such inequities. MacKinnon (1997: 89) suggests that the majority of women comply with their role by not rocking the boat and challenging their subordinate position, even if it means the extinction of a 'self' or identity as separate from their role as primary caregiver. Baxter and Western (1998) found that women with limited options were more likely to accept their husband's minimal involvement in household chores as fair than women with greater economic resources and more options outside marriage. Dempsey (1999), on the other hand, found that perceptions of fairness in the gendered division of housework were based less on economic factors and more on whether the woman felt her work in the home was valued by her partner. Dempsey went on to suggest that women who felt valued were more likely to be satisfied with the overall quality of their marriage. Maushart (2001) claims that many women accommodate the existing inequities within a marriage believing that a flawed relationship with their male partner is better than no relationship. Either way, hegemonic ideas of gender relations become internalised as part of the normal social order. Reproducing such ideas can be so successful that, rather than admit to unhappiness within marriage, many women may exaggerate their husbands' virtues and hide any private hostility with 'public protestations of loyalty and affection' as a way to 'protect' their marriages (Maushart, 2001: 158).

### **Reproducing hegemonic gender relations in the face of social changes**

The study by Bittman, Hoffman and Thompson (2004) on men's uptake of family friendly employment provisions in two Australian companies found that, notwithstanding men's increased interest in fathering and sharing childcare, and corporations becoming more family friendly though offering flexible

working hours, only 18 per cent fathers used flexible hours to balance work and family and 73 per cent did not use a single family friendly provision. No more than two per cent of men switched to part-time work to look after their children. Over two thirds of fathers with pre-school age children said their partners were the usual carer of the children. Responses from employees, supervisors and managers suggest that men who increase the time they spend in childcare could damage their careers, highlighting a contradiction between changes in attitudes in the workplace and actual practice. Added to this, the researchers found that masculine identity and being the economic provider are powerfully entwined with both parents acknowledging the centrality of the father's career and not the mother's. Indeed, notwithstanding aspirations to share parenting more equitably, most men prioritised work over family.

These findings reiterate that dominant ideas of gender relations inform decisions about family responsibilities and the allocation of roles. For many men, being the breadwinner remains the top priority (Bittman et al., 2004: 182). In Britain, a survey of working couples showed that 75 per cent of participants saw the husband as breadwinner and the wife as the secondary earner, if she was employed at all. Only ten per cent of couples reverse roles, usually only temporarily, although this number is slowly increasing (Hakim, 2003b). Men's involvement in the domestic workload and childcare remains slight in Australia compared to women's and is usually arranged on their terms with little criticism levelled at men whose contribution is non-existent (Bittman et al., 2004; Dempsey, 1990, 1997b; McMahon, 1998).

Komter (1989: 208) analysed power in marital relationships in the Netherlands and examined the notion of an 'implicit hierarchy of worth' where cultural norms placed higher value on male as provider according them greater power within the marriage. Komter viewed power as relational but acknowledged the link between structural elements, such as the significance of economic factors and gender relations, on social practice in marriages. She defined power in marital relationships as 'the ability to affect consciously or unconsciously the emotions, attitudes, cognitions or behaviour of someone else' (p.192). She suggests that women's power to challenge the prevailing inequity in gender relations is suppressed when they choose to avoid conflict in their marriage.

Komter argues that women who find ways to adapt to dominant ideas of gender relations in marriage, however inequitable, legitimate the social order. Her findings showed that, in many cases, consensus between couples on the division of labour reproduced essentialist views of gender roles where childcare and domestic tasks were seen as 'natural' for women, who were seen to 'enjoy parenting more than men' (Komter, 1989: 209). Such views were also evident in Australian research on gender relations in a rural setting.

### **Marriages in a rural setting**

Dempsey's (1990; 1992; 1997a) studies on gender inequalities in marriage were part of his extensive research on rural Australia. His studies show that marriages are often so 'palpably one-sided that we are justified in describing them as exploitative' (Dempsey, 1992: 64). He also found that men *and* women living in rural locations often regard 'wifeness and motherhood as the natural and ultimate roles for women' and men are the 'family providers' (Dempsey, 1992: 171). Such essentialist views of gender are reflected in expectations that a wife supports her husband, not just in his occupation but also in his leisure pursuits and altruistic activities such as public service in the community where husbands 'cover themselves in glory' (p.64). If their husbands are in leadership positions, wives are expected to support them by freeing them up 'for play' (p.64) often at the expense of wives' own leisure activities, suggesting that a husband's claim to leisure is superior to a wife's. The belief prevails that, as breadwinner, the male is entitled to leisure time especially leisure time away from home (Dempsey, 1992). As a result, being responsible for supporting her husband and looking after the home and family constrains rural women's participation in the workforce and her own leisure pursuits. Rather than the load being equally shared between the couple, rural men conform to conventional stereotypes and 'help' their wives with childcare and domestic tasks as long as these activities do not encroach significantly on their own paid work and leisure pursuits.

Dempsey's research demonstrates perceptions in rural communities that men's role as provider is seen as superior to women's role by both sexes. In rural Australian culture, pervasive gender inequalities are evident in the notion that

men's work and needs are more highly valued than women's (Dempsey, 1990). As provider, men are entitled to more control in public and domestic affairs, a larger share of resources and more right than their spouses to pursue leisure interests. Their hegemonic status is reflected in their economic superiority that is endorsed by the community where women's inferiority is implicit (Dempsey, 1992). This is not to suggest that women begrudge this role. Many, according to Dempsey (1997b: 18), enjoyed carrying out some household tasks and looking after their husband and children, and valued the power they exercised in the home.

Alston (2005) also argues that gender is a defining feature of Australian rural community life. However, while hegemonic expectations of gender relations are open to contestation, their prevalence within the institutional structures and practices in rural communities is normalised rather than resisted, effectively marginalising women in roles outside that of caregiver. British and Australian research into women in rural communities offers numerous examples of women's careers taking second place to their mothering role (Alston, 2005; Halliday & Little, 2001; Little, 1997). Women who are highly educated and trained who move to a rural location often downsize their career aspirations by taking on unskilled work in order to fulfil their role as caregiver (Alston, 2005; Little, 1997). While limited opportunities for childcare in rural areas are a factor constraining women's employment choices, so also are expectations of women's role and identity. In a rural setting, expectations of women as primary caregivers impact on the gendered division of labour in the home and on women's ambitions in the workplace (Little, 1997). While it is important to recognise that multiple femininities exist in a rural context, Little (1997) nonetheless argues that certain characteristics are shared. Women's roles as wives/partners and mothers are considered a defining aspect of their identity which is given priority over their employment.

Women's doxic acceptance of their role as caregiver is reflected in the assumption that 'their employment necessarily took second place to their childcaring role' (Halliday & Little, 2001: 430). Empirical research in Britain on the provision and use of childcare in Devon revealed that 95 per cent of the primary carers in the study were women, with 91 per cent of fathers working

full-time. To accommodate their caregiver role, many women worked shifts or night work often 'at the expense of their leisure or sleep yet they did not define it as a problem when asked about childcare arrangements nor did it emerge explicitly as an issue in their conversations' (Halliday & Little, 2001: 430). Women's reluctance to seriously question inequities in gender relations helps to sustain and reproduce hegemonic ideas and practices. This choice deflects attention from examining the fundamental inequity in an organisational structure of gender relations that privileges the needs of men over those of women. Women's lack of resistance to conservative attitudes giving them responsibility for childcare was reinforced in their responses in the Devon study suggesting that they considered men's employment more 'fixed and non-negotiable' (Halliday & Little, 2001: 434). Few women suggested their husband/partner change his working day or week to help with childcare. According to Alston (2005: 154), '[h]egemonic masculinity ensures that men have a stronger negotiating position around domestic labour and therefore may make themselves unavailable for household work'.

Women's responses not only indicate complicity with dominant views on gender relations, but also misrecognise the symbolic 'violence that is wielded' (Bourdieu & Wacquant, 2002: 168) where power is inequitably distributed to benefit men more than women. Seeking a clearer understanding of women's complicity warrants a deeper investigation. Women in their subordinate role are more likely to be valued in the current social order if they conform to dominant practices. Indeed, those who are married or in a committed relationship may accept their subordination in order to reap advantages such as social acceptance. In the case of doctors' spouses, such benefits may also include social status, material wealth and financial security, which they could stand to lose if they demand change to the structural inequities present in the prevailing social order. According to Finch (1983: 28), the wives of men who undertake 'noble endeavours' that curtail time spent at home, often do not express any relational conflict this may generate. Instead, they give their husband even '*more* space to get on with great work' (*italics in original*). Such evidence is reflected in findings from interviews with several female spouses of rural GPs who placed high value on the GP's work and justified the importance of their own role to support his

work and leisure pursuits. Male spouses of female GPs who were interviewed for this project also conformed to dominant expectations by earning an income or looking for employment, even if they were the main caregiver.

### **The social practice of being a rural GP's spouse**

I interviewed 21 spouses, 16 female and five male, about their expectations and experiences being married to, or in a committed relationship with, a rural GP. All but one couple had children. Eleven of the 21 spouses (52 per cent) were partners of OTDs. Ten of the 16 female spouses (63 per cent) conformed to expectations of their role as full-time support and caregiver to their partner and family. Six (38 per cent) were employed outside the home where all except one worked part-time with two employed in their partner's practice (see Table 13). Six women had given up their careers in order to move to the country and three spouses found there were no openings in their field. None in this group was in the paid workforce though four planned to find employment in future and two were undecided. One spouse continued working in her profession even though it meant living away from home for several weeks at a time. Two others had changed careers with one creating a position for herself in a different field where she worked part-time; the other was unemployed though planning to find work. Two spouses were studying, one of whom also worked part-time.

Five male spouses were interviewed: one enjoyed being the home-maker and worked part-time, one reversed roles with his wife for several months until he found work, one was planning to look for part-time work so he and his wife could spend more time together, one worked from home to look after the children and one was actively looking for employment.

Conformity to hegemonic gender relations was a strong theme in the responses of female spouses, all of whom carried the main responsibility for childcare and domestic tasks. While all male spouses were working or looking for employment outside the home, two resisted hegemonic expectations and also took on the major load of looking after the home and/or children.

The dominant role of rural GPs in the delivery of health services and the esteem in which they are held in rural communities are reflected in responses from spouses. Many considered the work of the rural GP as the pivot around

which the life of the spouse and family revolves. While male spouses worked or planned to work outside the home, female spouses' wish to develop an identity as separate from that of doctors' wife by finding employment or furthering their educational aspirations was often contingent on meeting the needs of their partner and family first.

### ***Moving to a rural area***

Even though some were ambivalent about the decision eight female spouses (50 per cent) moved to a rural area mainly to accommodate their partner's choice. Notwithstanding their partner's wishes and the better opportunities offered their children, not all wanted to leave the location in which they had lived before coming to Australia:

I was very happy where we were, working [in my career] which was fantastic. ... I dug my heels in initially because I was pregnant at the time and we had bought a lovely new house and were getting settled. So, for me, it was very difficult to make the decision. I was secretly hoping we would stay. But when I saw how unhappy Graham was, I thought, well, what have we got to lose, we may as well go. ... Ultimately if Graham is not happy then it affects the whole family (OFSP3).

Another spouse was also reluctant to move to a rural area because of lack of career opportunities:

...moving away was like saying I can't go back to work in that field. ... I loved my work (AFSP1).

Two made the choice to move because their partners were 'unhappy' (OFSP3, OFSP4) in their job, thereby considering their partners' happiness over their own. Another woman eventually encouraged her husband, who was reluctant to leave his work, to move to rural Australia because of dangerous living conditions in their country of origin. Farm invasions were common, food was scarce, local currency was devalued leading to greater insecurity and fear as law and order broke down. Despite such conditions this spouse commented that 'you kept believing that things would improve, so you stayed' (OFSP2). One woman, whose husband had always wanted to practise medicine in a rural area, agreed to move:

I have just always known that and accepted it. I never made the conscious decision that I wanted to live in the country (AFSP2).

Spouses' willingness to accommodate the needs of their partner and family reflected their supportive role. One spouse measured her own happiness in her success in the role of caregiver:

Family is most important. If my husband and children are happy, I'm happy (OFSP6).

### ***Conforming to hegemonic gender relations***

Female spouses conformed to dominant expectations of gender roles by prioritising their husbands' careers over their own educational or occupational aspirations. They organised their lives around the work practices and leisure time of their GP partner. One woman with older children reflected on these choices:

In those days, I was quite content to fit in and be the good wife and mother where everything is for the kids or the family or the husband. ... I just accepted it as my lot. When you married a doctor, you knew this is what happened (AFSP7).

This response was not uncommon in current young mothers:

Edward is pretty strong about having the mum home, or, you know, a parent at home to look after the children when they are very little. I can definitely identify with that. It hasn't been such an issue for me to get back to work (AFSP1).

Women's role as carer was further legitimated when GPs validated their spouses' support:

Max is fantastic and said he couldn't do his job if he didn't have someone there behind him to smooth the way and make sure there is food in the cupboard (AFSP2).

Female spouses prioritised not only their supportive role, but also the dominance of the medical profession where many considered their husband/partner's work as a rural GP more important than their own career or educational aspirations. Some spouses legitimated their primary caregiving role as necessary for doctors to successfully carry out their work in rural general practice:

Everything revolves around Aiden. [GPs'] jobs are so important and their physical, psychological and emotional wellbeing are so important. I cannot compare the job they do to anyone else's in the world in terms of the demands placed on them. The public lacks insight that they sit up all night with a sick child and then go to work the next day. They need to debrief at the end of the day and [the spouse] has to have the time and energy to support that. ... Wives are so essential especially in remote areas. If the wife isn't there the whole thing crumbles (OFSP8).

The work of rural GPs was seen as vocational, noble and self-sacrificing, occupying centre-stage to the wife's backstage role.

The importance of his work is so deeply ingrained. The whole house revolves around him getting to the hospital on time. His whole day is self-focused and the wife runs round and picks up all the pieces. Without the wife doing all that, [the GP] falls apart (AFSP7).

Nonetheless, some women found it 'frustrating' (AFSP2) when they were unable to meet their social or educational commitments because of the demands of their GP partner's work. Rather than prioritise their needs and negotiate options with their partner to facilitate meeting those commitments, one spouse subordinated them and rationalised that the needs of the patient were more important than hers:

It is just the way it is. It is the nature of the work. Most good doctors care about what they are doing and they want to do a good job...I really admire a doctor who takes pride in staying back 15 minutes to talk to a family who has had a major trauma. If you don't accept it I don't think you survive in the relationship (AFSP2).

Such comments were offset by:

... huge expectations for male doctors to work long hours, full-time and take no part in child rearing at all. Wives are expected to emotionally support their husbands (AMGP10).

One spouse suggested that rural GPs' wives 'were like women in the 1950s who devoted their lives to caring for husband and family rather than developing their own identity' (AFSP3). She revealed the tension in trying to meet dominant

expectations and her own needs concurrently, commenting that, even if they worked outside the home, wives felt they were in a no-win situation because:

Who will look after the children? If [the GP] is on-call who is going to maintain the home? It is a huge dilemma. That is why we aren't working (AFSP3).

Yet, by staying at home, some women felt 'unfulfilled' (AFSP3) and 'frustrated' (OFSP1). Nonetheless, decisions centred on giving priority to their husband's work over their own career reflecting fundamental assumptions of their subordinate role in gender relations. While this choice reaped certain advantages in terms of status and material wealth, there was often a price to pay.

### ***The cost of conformity***

Doctors earn a helluva lot more by being a GP in the country [which] does give you access to a lot of things (AFSP3).

According to Rhodes (2001: 353), wives of high earning professionals who give primacy to their husband's occupation over their own gain certain benefits, not least 'financial security and a comfortable lifestyle'. This belief belies any negative consequences of their caregiving role on a woman's sense of wellbeing that may be compounded by cultural, social, professional and geographic isolation:

I feel very stifled. ... I also have the issue where most of my friends work so it is quite lonely (AFSP3).

Another spouse echoed her sense of isolation:

I was very much alone. I spoke to myself and said you are not getting in to a rut; get on with life. ... Sometimes I get angry with him because I am not a housewife. I kept it inside for some time and one day I blew (OFSP1).

One spouse, who was having difficulty coping with the encroachment of her husband's work on family life, accepted the situation resignedly:

I feel at a loss as to what can be done about it. It is [his] lifestyle choice. He wants to do what he wants to do and I want him to be happy and that is important. It is important for him to know what he wants out of life (AFSP1).

The effect on family life of male rural GPs' intense involvement in their practice revealed a spouse's sense of entitlement to her husband's time that was often thwarted by the demands of patients:

They want the best for their patients. But, just for once it would be nice if he came home early. I feel the disruption more now I have kids. Just for once it would be nice if we had a turn (OFSP3).

One older spouse reflected on the long-term consequences of her partner's passionate commitment to his work in her life:

Well, I sometimes think would it matter if I was here or not because he is so driven? He loves his job and the truth is that when he is at home he is burnt out, really switched off (AFSP3).

Her sense of disillusionment is evident as she competes with her partner's work for demands on his time where 'everything is legitimate because the patient is in need' (AFSP3). She reflected that his role as a GP offers him a 'legitimate place to listen and ask [patients] questions [where] you don't have to give of yourself'. The effect of this emotional disconnection became a way to avoid 'relating to me on an intimate level'. She commented that being a rural GP in private practice 'is a big price to pay in terms of relationships'.

Comments from women about the degree to which patients 'adored' (AFSP7) the GP who was a 'wonderful doctor' (AFSP4) and a 'wonderful man' (AFSP5) were not unusual. Yet, such comments reinforced the lesser value felt by spouses in the face of the important work carried out by their GP partner.

### ***Identity***

One spouse commented that her sense of identity was relatively invisible in relation to the esteem in which her husband was held in the community:

You really are a nobody. People are interested in you because you are the doctor's wife, not because of you as a person. ... I like being a doctor's wife, though, and hearing people speak highly of him. I feel proud of him (OFSP2).

The theme of being perceived by the community to have no separate identity outside that of a doctor's spouse is reflected in other comments:

I keep on being introduced as the doctor's wife whereas I am also a professional. It is the first time I have been introduced like that. ... It is just here that people don't know what I have done and where I come from. I am seen just as a full-time mum (OFSP3).

However, while being a GP's wife had benefits in terms of social status, material wealth and financial security, other disadvantages were also discussed in terms of perceived social and emotional costs. Some women felt they were 'under scrutiny' and 'living in a goldfish bowl' (OFSP6) with others feeling disillusioned at the loss of an identity separate from that of rural GP's spouse, a role which tended to usurp all others. In interactions with community residents one woman commented:

The only communication I have is about him, not about me. So I go somewhere and they tell me all about my husband. Nobody is really interested in me. It is like I am the appendage (laughs). If I don't agree that he is the most wonderful thing ever to be born, then we have no conversation. It is like I don't really exist; just a shadow I guess (AFSP7).

Nevertheless, women were often protective of their GP spouses' interests, despite the emotional consequences of his work on their relationship. Coming to terms with these consequences was not easy in a rural town where discussing anything negative about their partner was generally not considered an option. This choice often led to a sense of social isolation:

There wasn't any support. In country areas doctors' wives are separate. The doctor's wife feels different. If she talks about confidences to people it might get around town, and what you are saying comes back to the husband's reputation. So you can't really say a lot about what is going on in the marriage because it is his reputation at stake. So from that point of view you feel duty bound not to talk about things. The difficulty is that people come up to you in the street and say: "oh, he's such a wonderful doctor, such a lovely man" and you feel bad that you have a problem with him. So you can't really open up about those issues. [You have to be] loyal to your husband otherwise his whole name suffers in the town so you can't say anything (AFSP7).

Upholding the good name of their GP partner is also preferable from a business perspective:

I don't talk to anyone in the community because, from a business perspective I can't be putting down Adam ... because they all think he is fantastic (AFSP4).

Spouses also mentioned other social constraints on their behaviour as a result of expectations of their role as the spouse of the GP. Some women commented on the sense of responsibility they felt as the doctor's wife to 'be good and set an example' (OFSP6) to the local community 'like not drink when I am pregnant' (OFSP3) or even to 'dress properly' (OFSP8) and:

... look decent and put your lippie on to whiz down to the town because people know who you are (AFSP2).

One woman in a small rural town in an isolated area explained this behaviour in relation to living up to expectations in the community:

You never let down your guard. I never discuss personal issues with anyone. There's no escape. If you have a problem in these little places you wouldn't go to anyone because you are supposed to be perfect (OFSP8).

Many spouses went beyond the call of duty by supporting, and justifying, not only the GP's work but also his entitlement to leisure even if his relaxation pursuits did not include her or the children:

He plays sport all the time and he has to do that to relax. He is not really a lie around home sort of person (AFSP4).

Rather than challenge any inequity, many wives justified their choice as part of their role of being a good wife, which led one to comment bemusedly:

I don't think [me being low on the priority list] is intentional. But I have to say this about doctors, they have an incredible arrogance. It is as if, "well, I'm saving the world, I deserve to have this time to do my own thing when I have time off. This is important. I have got to do it". Like nothing else is as important (AFSP3).

One woman reflected on the possible outcome of spouses seeking to change their subordinate position by seriously questioning pervasive inequities in their relationship with their GP partner:

The financial issues are huge, absolutely huge. I know a couple of wives who stay there for the money, though they would probably never admit that. It is the lifestyle, the children at private school, nice clothes, going to the best hairdresser and not having to work (AFSP7).

This response suggests some of the material advantages in being a doctor's wife. It also implies that her social status reflects her partner's important role as the local GP in a rural community. Her position as his spouse also provides her with economic security and the promise of a comfortable lifestyle. However, she may subjugate any aspirations of her own to the primacy of supporting her GP partner. Challenging power inequities embedded in her relationship may destabilise her already vulnerable position, given her economic dependency on her partner. She may not be prepared or want to do that. Meeting and valuing her own needs requires that she recognise and wrestle with the importance of a 'self' as separate from her role as doctor's wife and negotiate how these needs can best be expressed. Not every spouse fitted the mould of the doctor's wife whose life and identity revolved around her GP spouse and family. A few were determined to meet their aspirations outside those of caregiver.

### ***Multiple femininities***

Some women, whilst supporting their husband's work, created and maintained an identity separate from that of rural GP's wife, which often caused tension. While opportunities to work locally in their chosen profession were often limited or non-existent, a reality that often led to frustration, one spouse spent many weeks every year travelling away from home to pursue her career. She had moved to a rural centre to support her husband's work and was reluctant to stay long-term:

I am not dying here. There is a time limit to how long I can stay here. Fine for my husband...but for me I have tried every possible way [to meet] people because I hate just sitting at home and doing housework because that is not my life. I get very frustrated and angry. He used to go to work and have things to tell me, but I had nothing to talk about. ... Nothing will make me want to stay here. There is nothing for me here. I want a purpose in life. Not the purpose of getting up and doing the housework and waiting for the husband to come home for

lunch. I would like to have [the choice] to do things. I will never belong here (OFSP1).

Most women in their role as the main caregiver were unwilling to subjugate their educational or occupational aspirations indefinitely. Some resented their partner's sense of entitlement when their own needs or identity, separate from those of 'doctor's wife,' were not honoured in their own right, often leading to tension in the marital relationship. Spouses 'fitted in' their work or study after they had met the needs of the GP and the family. One spouse had switched careers and given up the opportunity for post-graduate study by accommodating her partner's wishes and moving to a rural area:

I sort of resented that. I'm over it now and I couldn't go back. Well, I could but it would mean I would have to move to the city to do it. It's pretty hard to do external studies (AFSP4).

Few spouses had seriously considered the option that GPs, who 'work so hard' (AFSP3), might modify their work arrangements to enable their wives to work. Instead, women implied that there was little room to negotiate beyond their accommodating role, not least because 'he makes more money so it is obvious that he works and I look after the kids' (AFSP3). Any sense of inequity was over-ridden by rationalising the need to support the important work carried out by the GP. However, feelings of resentment surfaced when GPs were apparently unaware of their spouses' support:

He asked how I had been supporting him which made me very angry. I said that for him to have a balanced life, you have a family to come home to at night. And I have contributed to the practice, made a lot of suggestions. ...What I do doesn't feel valued (AFSP3).

Female spouses who did not conform to their prescribed roles were often marginalised. Should the marriage break down, the wife, rather than the institutional structure of rural general practice was more likely to be held to account. According to one male GP:

A lot of doctors want to come to country areas. Most doctors will go anywhere. It is their wives. It's always the same. If you want to come to the country you can't marry a city girl. It is just a no-no. It is really terrible. ... If your spouse is happy, you

can go anywhere. We have had so many spouses down here who have made their husbands' lives miserable and have either left or separated. Or they lead funny, separated lives where the wife stays with the children in Perth and the GP stays down here. A funny sort of existence (AMGP 11).

From this response, negative judgements ensue about rural GPs' spouses if they allow other priorities take precedence over their supportive role. For one woman who pursued her interests, conflict and isolation, rather than cooperation and understanding, were the outcomes:

My whole study experience was quite lonely. It was very much my thing where the family, even Simon, were not involved. I did [my study] in between the washing and the cooking and the bringing up the children. I didn't really feel supported by the family. They came first and if I got my study in, that was good. I think Simon saw it as a hobby, a nice little hobby. A little patronising really even though he knew it was important to me. There are days when I am very pissed off when I have said to Simon "I don't want to do this any more". I actually feel like I have sacrificed a lot of myself because of Simon's role. I get frustrated because I feel like I have got my wings clipped all the time (AFSP3).

This response reveals disillusionment with the inequity of existing gender relations where any needs spouses had outside the home were permissible only if they fitted in with the pre-existing organisational structure of the family. This participant noticed that, as the children became more demanding:

... he seemed to work a bit more. I think he sees [childcare] as another chore that he really doesn't want to do ... It is far more stimulating to go to work. ... Staying at work to finish all the paperwork and books is probably more relaxing (AFSP3).

This participant was aware of costs of such the inequities and felt resentful enough to consider leaving the marriage:

In a sense when you are married to a country GP you always come last. The priorities are amazing. In my circumstances I find it amazing what Simon will put before us and it causes problems and I have laid down some ultimatums and have been ready to go (AFSP3).

Another woman reflected that spouses of rural GPs wanting a life outside their supportive role was unrealistic at best:

Spouses often don't get a look in for their career. If their partner is happy in medicine, well, you accept that. That's all you really need. You wouldn't want icing on it. Just a nice cake will do very nicely (AFSP6).

### ***Downsizing career aspirations***

Most female spouses of rural GPs had professional backgrounds such as medical imaging, pharmacy, nursing and teaching, yet few currently worked in their profession and all were economically dependent on their husband/partner. This raises questions about the notion of professional under-achievement amongst this group of women. Institutional constraints conspired against some professional women who had trained overseas yet their qualifications and experience were not recognised in Australia. One highly qualified professional woman had worked for many years in her chosen field in her country of origin. Arriving in Australia she was confronted with obstacles that precluded early employment:

Coming here [the professional governing body] won't acknowledge my qualifications. It will take me five years to pretty much do whole training again. There is an exam in two stages. The first stage is two papers about all your pre-graduate work. You have to pass both papers before you can progress to stage two consisting of two thousand hours of practical work and assignments and going to Perth for courses. After that you take another exam and then they consider whether you are good enough to [practise]. I am not going to do it. It is just too much that they ask for that (OFSP4).

Added to this, opportunities in a rural area in her chosen field were limited. While she did not rule out the option of employment in the future, she had downsized her aspirations:

Eventually, if I find another job, I will do it. I actually thought of finding out if there is a technical college here and doing a secretarial course and do some job that is wanted here. They all want childcare (OFSP4).

Some younger female spouses who took responsibility for childcare hoped to find employment in their profession once their children were at school. One, who had given up her career to look after her husband and children, hoped her husband would reciprocate in future and support her:

We have put his career first, I suppose, and kids growing up to school age too. ... I would perhaps hope down the track that he would help me out. I know it would be reciprocal, when he could do it, because that is the sort of person he is (AFSP1).

Conforming to the role of caregiver, particularly for spouses with young children seemed to supersede any desire for current employment outside the home:

My main focus at the moment is [my children]. When they are at school, I would really like to work again. But I don't have any set idea. I don't want to work full-time...My responsibility is to look after our children on a day to day basis (AFSP2).

### ***Resistance to structural constraints***

While hegemonic beliefs about gender relations were played out in social practice, the importance attributed to the GP's position by rural communities further constrained spouses' choices to meet their needs outside their supportive role. One spouse suggested that the community 'doesn't set [GPs] up as a deity but does put them on a pedestal' (AFSP3) which led to GPs being 'full of themselves' where they like being 'top dog' (AFSP3). Some wives considered they were the GP's 'reality check' (AFSP3, AFSP4):

It is only through me pulling him up and being a dragon that he gets his perspective back again because I think he loses perspective. I actually think GPs have a very narrow perspective on life. There is no time, no breathing time. They have so many demands on them (AFSP3).

Rural GPs are expected to work long hours which 'really does encroach' (AFSP4) on their home life as the GP 'does not treat the family as sacrosanct [because] work takes precedence' (AFGP3). Most rural GPs were enthusiastic and passionate about their work, despite its demands and stresses, with one commenting he 'enjoyed every day' (AMGP7) in rural general practice. Their commitment to their work is reflected in their spouses' responses:

I think they think they are irreplaceable. [They think] "if I am not there, things will fall apart. People are relying on me to be there". No one is irreplaceable (AFSP2).

Spouses voiced their reservations about such commitment which one considered 'stupid' not least because 'your relationship suffers and I resent that' (AFSP4).

Others spouses pondered the consequences of long and demanding working hours should the GP become ill:

He will not take a day off sick. He has got to go into work.  
They think they are indispensable (AFSP7).

Another spouse from a small rural town in an isolated location imagined the reality of GPs not being indispensable:

What happens if something happens to [GP]. If she gets cleaned up in front of the house who the hell is going to fix her (AMSP1)?

One woman contested the 'noble' role of her GP partner by reflecting more deeply on the notion of power embedded in his position at work and in the community and its effects in the GP/spouse relationship. When asked about spouses subjugating their own interests to support those of their partner, she commented:

I believe [GPs] need to be needed and they will often become doctors because it is a very satisfying profession...but in the end, that feeds the ego. For a lot of them it is more than duty, ... it is being important and that goes on in their working life and patients adore them for it. At home they may not get that adoration. ... A lot of doctors have a lot of power. They might not be aware of it or be very nice with it but there is a lot of subtle power and they do need to be dominant. A lot of the doctors' wives have been submissive to the extent they will give up their career, travelling, anything they may want to do on their own and bow down to their husband's wishes because he is superior, because he does this wonderful work, and they can't actually match him (AFSP7).

Such comments offer an insight into the consequences of women's doxic acceptance of the imbalance of power in the marital relationship. Women who comply with traditional gender roles that give primacy to supporting their GP partners are often implicitly required to subjugate any aspirations that conflict with that role, despite its effect on their sense of well-being. One spouse considered the early days of her marriage:

My identity was completely tied up with his. I was part of the machine. I was too busy with the kids and I didn't know any better. I had never been exposed to [feminist] ideas. I had been

brought up in the work ethic where loyalty [was important] and [I had been] sheltered. There was nothing in me. Everything was for him. I can't explain that any better. I was numb maybe and it didn't reach me (AFSP7).

Many spouses continue to accept their subordinate role. However, some feel angry and frustrated that their GP partners gave so little consideration to their need to develop a sense of identity and autonomy separate from their role as GP's spouse:

I felt I was doing it all on my own but I always wanted a slice for myself which is what my study was about, otherwise you get snaffled up in this all consuming life of being the doctor's wife and making it happen for one person. I guess I was making a point. I am a person too. I squeezed it in. But that is what a lot of people do. I am not alone (AFSP3).

Expectations and experiences of male spouses of rural GPs revealed a different story.

### ***Male spouses***

Of the five male spouses I interviewed, all conformed to their role as provider by either working or looking for paid employment. There was a far greater acceptance in rural communities that male spouses will work outside the home, reinforcing conventional gender stereotypes. One male spouse had recently found full-time employment, one worked part-time, another ran his own business from home. Two were in the process of seeking employment. The hegemonic role of male as full-time provider was destabilised by variations in work practices such as role reversal and working part-time. Responses to those variations were mixed, revealing tensions underpinning the notion of multiple masculinities.

### ***Multiple masculinities***

One male spouse was well aware of the importance of GPs to rural areas, and commented wryly that, as a male spouse, the community expected him to work outside the home, unlike his female counterparts. He had reversed roles with his GP partner, happily worked part-time so she could fulfil her career aspirations as a full-time rural GP and he could have more time to pursue non-

work activities. Another male spouse had made the decision with his GP partner that they both work part-time, having run their own business for several years which involved long working hours. Moving to a rural area was a long-term, lifestyle choice where they planned to spend more leisure time together as a couple and as a family.

While some female spouses conformed to social expectations and gave up their careers to support their GP partner and family by taking on the caregiving role full-time, all male spouses either earned an income or were looking for employment on top of their caregiving role. They generally found work in their original career, occasionally modifying their work practices by working from home. One man expressed clearly the sacrifice he had made in giving up a 'bloody good job' to reverse roles so his wife could work full-time:

Margaret would never have been able to come here if I didn't have a job where I could work from home or was prepared to just give it all up and be at home (AMSP1).

He continued to manage his own business from home and help with her general practice. When asked whether the demands of Margaret's work encroached on family life, his comments played down her working hours when compared to the long hours he worked in his previous employment

A long day at work for Margaret is eight hours and a long day for me was 14-18 hours. ... Margaret comes home for lunch every day. I don't think I have ever had a lunch break that I can recall (AMSP1).

However, as Connell (1977) suggests, dominant ideas can be contested and changed. In the context of gender relations, expectations for male spouses to meet the role of main provider were offset by a counter-hegemonic belief in the importance of their role as caregiver:

I guess I underestimated how [the demands of Margaret's work] would affect having children. So I much prefer to spend time with the children than be at work. ... That time with children you can never get back. Friends with older children missed out on that because they were working too much (AMSP1).

However, other men found coming to terms with reversing roles more difficult despite their choice often being a temporary arrangement where there was ‘an end in sight’ (OMSP2). One spouse felt his sense of masculinity was compromised in the caregiving role which he did not consider ‘manly’ (OMSP2) and struggled not to withdraw socially and isolate himself from the community. Despite valuing the extra time being a caregiver gave him to spend with his children, he consoled himself with the knowledge that, ‘deep down, I knew I was a lawyer’. However, once he found full-time work his spouse reduced her hours to become the primary caregiver. One female GP considered that her husband’s sense of masculinity was compromised when he was without paid employment. She expressed her discomfort that her spouse had been unable to find work while she was employed full-time; she felt responsible for his predicament.

He is very clever. I am nothing. I am just a small doctor here to treat some people. He has so much knowledge. ... I would not have come to a [rural area] if I had known my husband getting work would be this difficult (OFGP1).

Participants’ responses indicated that dominant expectations for men to earn an income were strong and tied up with notions of masculinity, even though some men contested this position by reversing roles with their GP partner. Nonetheless, all men either provided economically for their families, or planned to, with none taking on full-time the role of caregiver.

The influence of structural factors on social practice is evident in rural GPs’ spouses’ responses to dominant expectations of gender relations where most conformed to conventional notions of masculinity and femininity with male as provider and female as primary caregiver. However, a dialectical relationship between structure and social practice was also revealed when some resisted such norms. Their resistance, while causing tension, had the potential to lead to change.

### **The future of rural general practice**

Examining the dialectical relationship between structural issues and social practice offers a broader perspective to view difficulties recruiting and retaining GPs and their spouses in rural locations and provides a more nuanced

analysis of the complexity of the issue. The effects of resistance to dominant expectations of the social practice of gender are seen in female spouses seeking employment outside the home, or male spouses reversing roles with their GP partner, both often leading to tension as different individuals and groups struggle to meet their respective interests that often conflict with the so-called norm. This struggle is set against a backdrop of political and economic changes where the effects of rural restructuring and development have also constrained spouses' choices to work outside the home particularly in locations where a range of services, educational or training opportunities have been withdrawn. For spouses of rural GPs wanting to further their careers or education and training, the effects of such structural influences need attention when considering recruitment and retention issues and planning future rural general practice services.

Interviews with male spouses of rural GPs indicated the power of structural influences on social practice giving credence to the view that notions of masculinity and the role of provider are powerfully entwined. Tension was evident in the discomfort felt by some male spouses who resisted such expectations by reversing roles with their GP partners to become the primary caregiver. However, all male spouses were employed or were looking for work outside their caregiving role. By making this choice, they were meeting social expectations of masculinity and conforming to their role as provider. In all cases, the decision to find paid employment was supported by their GP partners and the local community.

Dominant expectations of gender relations also influenced the social practice of female spouses of rural GPs who conformed to the role of primary caregiver. The exalted position the male GP holds in a rural community, the demands of his work and the prescribed need for a supportive 'wife' impacted on expectations of his spouse's role. Structural constraints on female spouses' choices sometimes caused tension as women who wanted to pursue other interests struggled to balance their individual needs with those of their role as primary caregiver. Such constraints often reinforced women's subordinate position by giving primacy to their caregiving role. Conforming to that role elicited approval and support in a social context.

Tensions were revealed in responses from women who contested their hegemonic role by seeking a sense of identity separate from that of 'doctor's wife'. The imbalance in power between the male rural GP and his female spouse often constrained the woman's sense of entitlement to seek fulfilment outside their role of 'doctor's wife', particularly if it conflicted with the work of the GP. Bourdieu's (2002) notion that women misrecognise the inequitable distribution of power in their relationships as a form of symbolic violence is evident in the responses of some female spouses. The pervasiveness in social practice of many women's doxic acceptance of their role as caregiver emerges when they legitimate its importance as part of the normal social order rather than acknowledge its oppressive nature. Indeed, the notion that 'if he's happy, I'm happy' reinforces a sense of identity that is dependent on, and merges with, that of their partner.

However, the price, it seems, of conformity is often the renunciation of a significant part of their identity or sense of self that is separate from that of doctor's wife. This was exacerbated when educational and employment opportunities were limited in rural towns. Despite this, Dempsey (1992) argues that, while there may be an underlying current of resistance from some spouses, few women seriously contest the prevailing social order and do not expect change either in the organisation of domestic labour or in their male partners. Indeed, legitimating the value of their caregiving role by subjugating any educational or occupational aspirations that compete with the GP's role as provider maintains their dependent position.

In other words, conforming to dominant gender practices and not questioning structural inequities embedded in dominant beliefs about gender relations effectively reproduces them. To seek to understand women's complicity in subordinating their aspirations outside their caregiving role requires acknowledging the effects on their identity or sense of 'self' of misrecognising the symbolic violence that treats their needs and aspirations outside dominant expectations of their role as inferior. By reflecting on the effects of such inequities, women can consider what they may stand to lose, or gain, if they contest such expectations. Despite their own needs often being treated as inferior, their work devalued and their aspirations limited, responses suggest that

reproducing hegemonic practices seems preferable to the alternative which may extract too great a cost on female spouses' social and economic wellbeing particularly if they have become deskilled or have downsized their educational and occupational aspirations.

However, some women want changes so that expectations outside their role as caregiver are met and valued. Currently, meeting their own educational or occupational needs is an important factor affecting their sense of well being. The process of doing so, however, is often difficult and is generally contingent on giving primacy to their caregiving role. Nevertheless, the hopes of those women with expectations and aspirations beyond that role are important when considering issues related to recruiting and retaining GPs and their families to live and work in rural locations.

## Conclusion

This project was first formulated by working on a problem identified by the Great Southern Division of General Practice (GSDGP), namely the difficulty in recruiting and retaining GPs in rural locations. The area covered by the GSDGP includes the well-resourced, large rural centre of Albany, medium sized centres with fewer resources but populations large enough to support one or more group practices, and small rural centres where medical services are provided by a solo GP. Small rural centres are often located at considerable distance from larger centres. GPs practising medicine in rural areas face not only professional difficulties associated with working in settings limited in resources and support, but they and their spouses also meet social and sometimes cultural challenges that affect their decisions to live and work in a rural location.

Recruiting and retraining rural GPs is not a newly identified problem. The problem has been at the centre of research, lobbying and policy for some decades, and it was not clear initially what could be added by yet another study. There were, however, a number of common elements in previous studies. They were mainly focused on the GP, and on family members only in so far as they were 'variables' in explaining problems faced by GPs. Studies often centred on expectations and experiences of GPs intersecting with the perceived disadvantages of living and working in a rural environment. In addition, there were a number of matters where previous research revealed little acknowledgment or critique which this study showed to be important such as assumptions regarding the gendered division of labour. Many studies have also worked within the paradigm which put medical practice and doctors at the centre in rural health service delivery. Given the reluctance of Australian trained medical graduates to move to the country, health policies have opened the door to recruiting increasing numbers of OTDs as a temporary solution to provide services in rural settings while still maintaining a medico-centric focus. However, in locations unable to attract doctors, senior registered nurses have provided health care but as a 'second best' option. The radical changes to medical practice wrought by neoliberal policies are another factor warranting

examination in the context of recruiting and retaining rural GPs. Such policies are simultaneously committed to market deregulation and the demand for accountability in areas where it is not possible for markets to exercise discipline over practitioners. Health budgets have been declining or growing less rapidly at the same time as bureaucratic requirements for accountability have been increasing. For all kinds of reasons, this mix makes living and working more difficult in rural areas than in urban areas

This thesis expands the parameters within which to view the problem of recruiting and retaining GPs in rural centres. It locates the discourse within a broader social context by critically examining the effects of structural influences such as gender relations and the political and economic climate on the everyday expectations and experiences of rural GPs and their spouses. Findings show that approaching the issue this way offers a more complex, nuanced understanding of factors influencing GPs and their spouses to stay or leave rural locations. Examining the dialectical relationship between structural factors and social practice provides a framework in which to more deeply analyse the issue.

The disadvantages faced by GPs living and working in a rural environment are well documented. While a rural setting cannot always meet the professional and lifestyle expectations of GPs and their spouses, keeping the debate centred on the needs of individual GPs and their families, or the disadvantages of rural 'space', works against critically examining the issue within a broader social context. Opening up the discourse to identify the effects of structural issues on social practice expands the parameters within which to view the problem and consider innovative solutions.

Despite recent social changes impacting on rural general practice and the perceived disadvantages of living in a rural location, findings from this study showed that most rural GPs interviewed had no intention of moving to a city to work. They experienced enormous satisfaction working as rural GPs, particularly if they practised procedural medicine such as obstetrics, anaesthetics, surgery or emergency medicine. Most felt fulfilled professionally, enjoyed the variety of work and the opportunity to practise continuity of care with their patients 'from the cradle to the grave'. Many were proud to be rural GPs and rural general

practice had been their first career choice. The majority of those interviewed espoused a male model of rural general practice involving long working hours.

Nonetheless, political and economic changes are affecting rural GPs' enjoyment of their work. Increasing government regulation in clinical practice and demands for more accountability for their work practices has diminished their sense of autonomy and control often leading to a sense of frustration. While such changes affect both rural and urban GPs, rural GPs are also faced with the negative effects of restructuring and development that have resulted in diminishing populations and a withdrawal of services in some rural areas making them less attractive places to work.

The expectations and experiences of rural GPs' spouses are also important when considering recruitment and retention but their social, cultural, occupational, educational or training needs have often been relegated backstage in terms of importance. This study has foregrounded the spouse's role in decisions to live and/or work in a rural location noting differences in expectations and experiences between male and female spouses. Findings highlighted the significance of structural influences on social practice particularly in the area of gender relations.

Some male spouses of rural GPs, while resisting dominant expectations by becoming the caregiver, also work in paid employment. Choosing to work part-time to support their GP partner frees them up to care for their children and/or to pursue leisure interests. Effectively, they are opening the door to expressing multiple masculinities that go beyond meeting hegemonic expectations of their role as provider. Most female spouses conform to dominant expectations of their role as primary caregiver. In the process they gain social approval, financial security and social status. Findings also revealed that the cost of such conformity for some female spouses of rural GPs is the subjugation of their sense of a 'self' as separate from that of wife and mother. Spouses are likely to become deskilled in their profession or occupation and are often financially dependent on their GP partner. Those who do pursue occupational or educational interests outside the home often attend to the demands of their caregiving role first or fit in their other interests around their caregiving role. However, as a

result of political and economic changes, services have been withdrawn in some rural locations thereby limiting opportunities for spouses of rural GPs wanting employment, particularly if childcare services are not available, making the probability of recruiting GPs to work in those areas less likely.

Few women in this study challenge hegemonic expectations of their role in the home. All female rural GPs are either married or in committed relationships and all but one have children. Many find it more practicable to change expectations of medical practice than to change the relationships between mothers, fathers and children. For female rural GPs with children, none question the centrality of their roles as wife and mother in their lives. Their identity as caregiver generally takes precedence over their role as doctor where, according to one female rural GP, 'most women doctors would say their core identity is as wife and mother and GP would be third' (AFGP5). Their choice to work fewer hours is often predicated on meeting the expectations of their caregiving role in the home. These findings support research in Australia and Britain that women and men's expectations of gender relations continue to fall along conventional lines. Findings from Dempsey's research on gender relations in a rural context support these conclusions.

Critically examining women's 'doxic' acceptance of the primacy of their caregiving role evokes the notion of symbolic violence embedded in the inequitable power imbalance in gender relations. Actions that subordinate the needs of women constitute 'symbolic violence' when they hide power relations at a structural level that limit women's choices at the level of social practice. This occurs without direct or overt coercion but as a result of women internalising their subordinate position as part of the normal social order (See Connelly & Healey, 2004: 15). Very few women challenge their role as the primary caregiver in the home. Those who do question inequities in the power balance in the division of labour and who are not earning an income risk losing their social and economic status should their circumstances alter. Generally, female spouses meet their occupational or educational aspirations by 'fitting them in' around their caregiving role. If such aspirations conflict with their caregiving responsibilities and cause tension with their partners, some female spouses withstand the tension and persist in meeting needs that honour their sense of 'self' as separate from that

of doctor's wife. In doing so they act as agents for change and indicate the existence of multiple femininities that resist not only the assumptions embedded in their caregiving role, but also its potentially oppressive nature.

The organisational structure of rural general practice has long supported a male model of work practice despite increasing numbers of women entering medicine and training as rural GPs. However a deeper analysis of the relationship between structural elements and social practice in this context is warranted in light of planning rural GP services in future. This study broadens the focus of previous research by examining the issue in relation to gender role expectations in both medical and rural contexts. While women may resist dominant expectations of work patterns in rural general practice by adopting a more flexible approach to working hours, findings show that compliance is contextual and not automatically transferred across settings. Agreeing to dominant expectations in one context may require resisting them in another. In order to meet expectations of their role as caregiver in the home, some female rural GPs require more flexible hours in the workplace, causing frustration amongst some of their male colleagues. Embedded within the notion of a dialectical relationship between structural influences and social practice is the potential for change that emerges from the tension generated as opposing views meet. The propensity of younger male rural GPs in this study, consistent with others of their generation, is to want a better balance between work and other aspects of life. Some younger male rural GPs support the reduction in long working hours as a way to balance work and other pursuits. Research from Britain reveals that older GPs also want change to their work patterns where they work fewer hours in order to attain more balance in their lives (Young et al., 2001).

Recruiting OTDs as a temporary solution to the shortage of doctors in rural areas is not without problems. Training more doctors in Australia with a view to filling those vacancies in the long-term assumes local graduates will want to work in rural areas but evidence has shown this is not the case. Filling those positions with doctors trained overseas has created an uneasy relationship between medical professionals. Recently arrived OTDs are accepted as 'good enough' in those rural areas unable to attract their Australian trained colleagues, but not otherwise despite their experience and expertise. This study has

addressed factors specifically affecting the professional and social integration of doctors trained overseas and their spouses and sought to understand whether the expectations they bring to Australia are adequately fulfilled in a rural location. OTDs from different cultural and linguistic backgrounds live and work in a variety of rural locations in Australia. Findings from this study indicate commonalities between OTDs and their spouses in expectations of life in Australia but also a diversity of experiences in rural general practice. Opportunities for their families and a better and safer lifestyle are big drawcards. Cultural dislocation, isolation and limited job opportunities for spouses in their chosen field are challenges to the integration process. Warm welcomes and acceptance by local communities help to offset feelings of loneliness.

In a political and economic climate where competition is encouraged, other health professions vie with GPs to offer health services that were previously the prerogative only of the medical profession. Some GPs see this development as inevitable. Many accept health professionals providing services in rural settings unable to attract GPs as long as the medical profession maintains its dominant role in rural health care. By effectively reproducing the dominant status of the medical profession, rural GPs implicitly regard the services other health professions offer as having less value. Uneasy relationships between medical and other health professionals are created where senior registered nurses or nurse practitioners are considered 'good enough' if there are no doctors available, but not otherwise.

What this study has done is allow rural GPs and spouses to express their ideas, thoughts, opinions, beliefs, expectations and experiences and open up questions in a space created by the ethnographic researcher. From this, it is possible to conclude that if we do not resolve the problems generated by:

a) an organisational structure supporting a male model of rural general practice in a climate where nearly 60 per cent of medical students are now women,

b) the desire amongst female and some male rural GPs for more flexible work practices to attain a balance between work and home,

c) the reluctance of locally trained medical graduates to work in the country,

d) the decision to provide more medical school places as a long-term solution to the rural recruitment and retention problem that is affected by a section of the Australian Constitution that prohibits any form of ‘civil conscription’ of medical practitioners to work in areas of need,

e) viewing OTDs as a short-term solution,

f) current political and economic restructuring and development of rural communities often leading to services being withdrawn, reduced employment, education and training and diminishing populations making the choice to work in some rural locations less attractive,

g) limited occupational, educational and training opportunities for spouses,

h) a medico-centric approach to rural health care making implementing innovative solutions outside that paradigm more difficult,

then we are not going to resolve the problems of recruitment and retention of GPs in rural areas. Not only must we be prepared to recast the problem in terms other than medico-centric ones if we are to meet the need for comprehensive and innovative rural health care, but we must also acknowledge the significance of the matters set out above. This is what this study has done.

The study has also raised various issues that are beyond the capacity of this thesis to explore but nevertheless indicate scope for further research, such as the following:

a) the impact on rural medical workforce planning of an ageing male rural GP workforce whose work practices involve long hours, growing numbers of women entering medicine who, along with some male GPs, want flexible working hours, and spouses of rural GPs who want to continue their careers,

c) marriages/relationships in which rural GPs and their partners are in full-time employment and the division of labour in the home is negotiated equitably,

d) underutilisation of spouses' skills in areas where employment opportunities in their chosen field are limited,

e) increased focus on viewing rural health care from a perspective that examines broader social issues that determine health such as the effects of unemployment,

f) the effects of diversity between rural communities when planning health care provision,

g) increasing the role of health professionals such as senior registered nurses/nurse practitioners and Aboriginal health workers in rural health care,

h) the effect of neoliberalist principles on changing the culture of rural health care.

The broader implications for anthropology and sociology from the findings of this study are also evident in various contexts. According to Bell (1978: 37), the notion of 'studying up' is important and 'sociology's attention should, for a while at least, be focused on the powerful and the consequences of their power on us all'. This perspective has influenced a critical examination of:

a) the position of the medical profession in the social organisation of rural health care and factors underpinning professional relationships between rural GPs and other health professionals in the current political and economic climate

b) expectations of gender relations in a professional context between male and female rural GPs,

c) expectations of gender relations in rural medical marriages and factors underpinning many female spouses' doxic acceptance of their primary caregiving role.

Such an approach opens the door to critically examining similarities and differences in other professional or elite groups such as dentists, lawyers or accountants in rural contexts and comparing them with similar groups in urban settings.

## References

- Abbot, T. (2004). *Budget 2004-2005 Health 1-6*. Canberra: Commonwealth Department of Health and Ageing.
- a'Brook, M. (1990). Psychosis and depression. *The Practitioner*, 234(November), 992-993.
- Access Economics. (2002). *An analysis of the widening gap between community need and the availability of GP services*. Canberra: Australian Medical Association.
- Alexander, J. (2000). The changing role of clinicians in Australia and New Zealand. In A. Bloom (Ed.), *Health reform in Australia and New Zealand* (pp. 161-182). Oxford: Oxford University Press.
- Alston, M. (2005). Gender perspectives in Australian rural community life. In C. Cocklin & J. Dibden (Eds.), *Sustainability and change in rural Australia* (pp. 139-156). Sydney: University of New South Wales Press.
- Altheide, D., & Johnson, J. (1994). Criteria for assessing interpretive validity in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 485-499). Thousand Oaks: Sage.
- Argent, N., & Rolley, F. (2000). Lopping the branches: Bank branch closure and rural Australian communities. In B. Pritchard & F. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 140-168). Sydney: University of New South Wales.
- Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248-261). Thousand Oaks, California: Sage.
- Australian Department of Health and Ageing. (2005). *Review of the rural, remote and metropolitan areas (RRMA) classification. Discussion paper*. Canberra: Australian Department of Health and Ageing.
- Australian Government Budget. (2003). *Australian Government budget rural health initiatives*. Retrieved March 10, 2004, from <http://www.ruralhealth.gov.au/policy/budget.htm>
- Australian Government Department of Health and Ageing. (2003). *Workforce support for rural general practitioners*. Retrieved March 10, 2004, from <http://www.ruralhealth.gov.au/workers/wsrp.htm>
- Australian Government Department of Health and Ageing. (2004). *Medicare Plus*. Retrieved September 17, 2004, from <http://www.health.gov.au/medicareplus/about/factsheets/fact09.htm>
- Australian Government Department of Health and Ageing. (2005). *General practice in Australia: 2004*. Canberra: Australian Government: Department of Health and Ageing.
- Australian Health Care Agreement Reference Groups. (2002). *A report to the Australian Health Ministers' conference from Australian Health Care*

- Agreement Reference Groups*. Canberra: Commonwealth Department of Health and Ageing.
- Australian Institute of Health and Welfare. (1999a). *Medical labour force 1997: National Health Labour Force Series* (No. HWL-13). Canberra: AIHW.
- Australian Institute of Health and Welfare. (1999b). *Medical labour force 1999: Labour Force Series* (No. HWL-24). Canberra: AIHW.
- Australian Institute of Health and Welfare. (2000). *Australia's health 2000*. Canberra: AIHW.
- Australian Institute of Health and Welfare. (2002). *Australia's health 2002: The eighth biennial report of the Australian Institute of Health and Welfare (AIHW)*. Canberra: AIHW.
- Australian Medical Association. (1994). *AMA position statements: Nurse practitioner statement*. Canberra: AMA.
- Australian Medical Association. (2001a). *AMA submission to the Commonwealth review of the impact of the Trade Practices Act (1974) on the recruitment and retention of rural doctors*. Canberra, ACT: AMA.
- Australian Medical Association. (2001b). *Geographic allocation of Medicare provider numbers: Position statement*. Canberra: Australian Medical Association.
- Australian Medical Workforce Advisory Committee. (1998). *Influences in participation in the Australian medical workforce* (No. 1998.4). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (1999). *Temporary resident doctors in Australia: Distribution, characteristics and role* (No. 1999.3). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2000). *The general practice workforce in Australia: Supply and requirements 1999-2010* (No. 2000.2). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2003). *Career decision making by doctors in vocational training: AMWAC medical careers survey 2002*. Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2004a). *Annual Report 2003-2004* (No. 2004.5). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2004b). *Survey of doctors working in rural and remote locations under Australia's five-year overseas trained doctor recruitment scheme: Report to the national review steering committee of the five year overseas trained doctor scheme*. Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2005). *The general practice workforce in Australia: Supply and requirements to 2013* (No. 2005.2). Sydney: AMWAC.

- Australian Medical Workforce Advisory Committee, & Australian Institute of Health and Welfare. (1996). *Australian medical workforce benchmarks* (No. 1996.1). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee, & Australian Institute of Health and Welfare. (1998). *Medical workforce supply and demand in Australia: A discussion paper* (No. AMWAC 1998.8, AIHW No. HWL12). Sydney: AMWAC, AIHW.
- Australian Rural and Remote Workforce Agencies Group. (2003-2004). *Annual report*. Canberra: Commonwealth Department of Health and Ageing.
- Australian Rural and Remote Workforce Agencies Group. (2004). *Overseas trained doctors and the rural and remote workforce: Policy position paper 2*. Canberra: Commonwealth Department of Health and Ageing.
- Baer, H. (1982). On the political economy of health. *Medical Anthropology Newsletter*, 14(1), 1-2, 13-17.
- Baer, H., Singer, M., & Johnsen, J. (1986). Towards a critical medical anthropology. *Social Science and Medicine*, 23(2), 95-98.
- Bates, T. (2002). Gramsci and the theory of hegemony. In J. Martin (Ed.), *Antonio Gramsci: Critical assessments of leading political philosophers* (pp. 245-262). London: Routledge.
- Battin, T. (1991). What is this thing called economic rationalism? *Australian Journal of Social Issues*, 26(4), 294-307.
- Baxter, J., & Western, M. (1998). Satisfaction with housework: Examining the paradox. *Sociology*, 32(1), 101-121.
- Beagan, B. (2001). Neutralising differences: Producing neutral doctors for (almost) neutral patients. *Social Science & Medicine*, 51, 1253-1265.
- Beeson, M., & Firth, A. (1998). Neoliberalism as a political rationality. *Journal of Sociology*, 34(3), 215-231.
- Bell, C. (1978). Studying the locally powerful. In C. Bell & S. Encel (Eds.), *Inside the whale: ten personal accounts of social research* (pp. 14-40). Sydney: Pergamon Press.
- Benjamin, O. (1998). Therapeutic discourse, power and change: emotion and negotiation in marital conversations. *Sociology*, 32(4), 771.
- Bernard. (1982). *The future of marriage*. New Haven: Yale University Press.
- Birrell, B. (1995). Immigration and the surplus of doctors in Australia. *People and Place*, 3(3), 23-31.
- Birrell, B. (1997). Hunger strikes and the accreditation of overseas trained doctors in Australia. *People and Place*, 5(4), 53-58.
- Birrell, B. (2001). Doctor dilemmas: How GP medicine is practised in Australia. *People and Place*, 9(3), 41-53.
- Birrell, B., & Hawthorne, L. (2004). Medicare Plus and overseas trained medical doctors. *People and Place*, 12(2), 84-100.

- Bittman, M., Hoffman, S., & Thompson, D. (2004). *Men's uptake of family-friendly employment provisions* (No. Policy Research Paper Number 22). Canberra: Australian Government Department of Family and Community Services.
- Black, A. (2005). Rural communities and sustainability. In C. Cocklin & J. Dibden (Eds.), *Sustainability and change in rural Australia* (pp. 20-37). Sydney: University of New South Wales Press.
- Black, A., Duff, J., Saggars, S., Baines, P., Jennings, A., & Bowen, P. (2000). *Rural communities and rural social issues: Priorities for research* (No. ECU-4A). Canberra: Rural Industries Research and Development Commission.
- Boffa, J. (2002). Is there a doctor in the house? *Australian and New Zealand Journal of Public Health*, 26(4), 301-304.
- Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory*, 7(1), 14-25.
- Bourdieu, P. (2004). *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Bourdieu, P., & Passeron, J.-C. (1977). *Reproduction in education, society and culture*. London: Sage.
- Bourdieu, P., & Wacquant, L. (2002). *An invitation to reflexive sociology*. Cambridge: Polity.
- Brines, J. (1994). Economic dependency, gender and the division of labor at home. *American Journal of Sociology*, 100(3), 652-688.
- Bryant, L. (1997, n.d.). *The voice of women in medicine*. Paper presented at the Royal Australian College of General Practitioners Conference, Hobart, Tasmania.
- Burns, R. (1997). *Introduction to research methods* (3rd ed.). Melbourne: Addison Wesley Longman.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. London: Routledge.
- Butler, J. (1993). *Bodies that matter: On the discursive limits of sex*. London: Routledge.
- Calnan, M., & Williams, S. (1995). Challenges to professional autonomy in the United Kingdom? The perceptions of general practitioners. *International Journal of Health Services*, 25(2), 219-241.
- Carson, D., & Stringer, K. (1998, August 27-28). *Generation and gender issues: The emerging culture within the rural and remote medical workforce: Cultures in caring*. Paper presented at the 4th Biennial Australian Rural and Remote Health Scientific Conference, Empire Theatre, Toowoomba, Queensland.
- Chernichovsky, D. (1995). Health system reforms in industrialised democracies: an emerging paradigm. *The Milbank Quarterly*, 73(3), 339-372.

- Chesters, J., Han, G.-S., Strasser, S., & Ballis, H. (2001). Doctoring rural towns. In J. Dibden, M. Fletcher & C. Cocklin (Eds.), *All change! Gippsland perspectives on regional Australia in transition: Occasional Papers* (pp. 71-78). Melbourne: Monash University.
- Christians, C. (2000). Ethics and politics in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 133-155). Thousand Oaks, California: Sage.
- Clearihan, L. (1999). Feminisation of the medical workforce. *Australian Family Physician*, 28(6), 529.
- Cocklin, C., & Alston, M. (Eds.). (2003). *Community sustainability in rural Australia: A question of capital?* Wagga Wagga NSW: Charles Sturt University.
- Commonwealth Department of Health and Ageing Divisions of General Practice Program. (2002). *Guidelines for the workforce support for rural general practitioners program under the Divisions of General Practice program*. Canberra: Commonwealth Department of Health and Ageing.
- Connell, R. W. (1977). *Ruling class, ruling culture: Studies of conflict, power and hegemony in Australian life*. Cambridge: Cambridge University Press.
- Connell, R. W. (1987). *Gender and power*. Sydney: Allen and Unwin.
- Connell, R. W. (1995). *Masculinities*. Sydney: Allen and Unwin.
- Connell, R. W. (2002). *Gender*. Cambridge: Polity.
- Connelly, P., & Healey, J. (2004). Symbolic violence, locality and social class: The educational and career aspirations of 10-11-year-old boys in Belfast. *Pedagogy, Culture and Society*, 12(1), 15-33.
- Conochie, I. (1990). Denmark: An outline history. Denmark, WA: Denmark Tourist Bureau.
- Crompton, R., & Le Feuvre, N. (2003). Continuity and change in the gender segregation of the medical profession in Britain and France. *International Journal of Sociology and Social Policy*, 23(4), 36-58.
- Cutchin, M. (1997). Physician retention in rural communities: The perspective of experiential place integration. *Health and Place*, 3(1), 25-41.
- Danziger, S. (1979). On doctor watching: Fieldwork in medical settings. *Urban Life*, 7(4), 513-532.
- Davies, C. (1996). The sociology of professions and the profession of gender. *Sociology*, 30(4), 661-679.
- Davis, A. (1993). Economising health. In S. Rees, G. Rodley & F. Stilwell (Eds.), *Beyond the market: Alternatives to economic rationalism* (pp. 119-135). Sydney: Pluto Press.
- Day, C. (2000). *Municipal heritage inventory review for the City of Albany*. Perth: Heritage Today.

- De Laine, M. (1997). *Ethnography: theory and applications in health research*. Sydney: MacLennan and Petty.
- de Vaus, D. (1997). Family values in the nineties. *Family Matters*, 48(Spring/Summer), 5-10.
- Delane, M. (2002, 22-24 April). *Help for WA medical families only a phone call away*. Paper presented at the Australian Rural and Remote Workforce Agencies (ARRWAG) Conference, Adelaide.
- Delphy, C. (1992). A theory of marriage. In L. McDowell & R. Pringle (Eds.), *Defining women: Social institutions and gender divisions* (pp. 138-140). Cambridge: Polity Press.
- Delphy, C., & Leonard, D. (1992). *Familiar exploitation: A new analysis of marriage in contemporary Western societies*. Cambridge: Polity Press.
- Dempsey, K. (1990). *Smalltown: A study in social inequality, cohesion and belonging*. Melbourne: Oxford university Press.
- Dempsey, K. (1992). *A man's town: Inequality between women and men in rural Australia*. Oxford: Oxford University Press.
- Dempsey, K. (1997a). *Inequalities in marriage: Australia and beyond*. Melbourne: Oxford University Press.
- Dempsey, K. (1997b). Women's perceptions of fairness and the persistence of an unequal division of housework. *Family Matters*, 48(Spring/Summer), 15 - 19.
- Dempsey, K. (1999). Attempting to explain women's perceptions of the fairness of the division of housework. *Journal of Family Studies*, 51(1), 3-24.
- Department of Health, W. A. (2003). *The country health services review: The way forward for country health services in Western Australia*. Perth: Department of Health, WA.
- Department of Primary Industries and Energy, & Department of Human Services and Health. (1994). *Rural, remote and metropolitan areas classification 1991 census edition*. Canberra: Commonwealth of Australia.
- Donovan, H. (2003). *Australian/State/Northern Territory national review. The five year overseas trained doctor recruitment scheme: The Western Australian perspective*. Perth: Department of Health, Government of Western Australia.
- Duckett, S. (2004). *The Australian health care system* (2nd. ed.). Oxford: Oxford University Press.
- Duff, J. (2001). Financing to foster community health care: A comparative analysis of Singapore, Europe, North America and Australia. *Current Sociology*, 49(3), 135-154.
- Duff, J., Larsen, A.-C., Tonts, M., & Ainsworth, F. (2000). *Entrepreneurialism in the service professions: The delivery of services in a competitive, market-driven global economy*. Perth, Western Australia: Edith Cowan University.

- Easton, B. (1997). *The commercialisation of New Zealand*. Auckland: Auckland University Press.
- Elston, M. (1991). The politics of professional power: Medicine in a changing health service. In J. Gabe, M. Calnan & M. Bury (Eds.), *The sociology of the health service* (pp. 58-88). London: Routledge.
- Elston, M. (1993). Women doctors in a changing profession: the case of Britain. In E. Riska & K. Wegar (Eds.), *Gender, work and medicine: Women and the medical division of labour* (pp. 27-61). London: Sage.
- Emerson, R., Fretz, R., & Shaw, L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- Encel, S. (1978). In search of power. In C. Bell & S. Encel (Eds.), *Inside the whale: Ten personal accounts of social research* (pp. 41-66). Sydney: Pergamon Press.
- Eve, R., & Hodgkin, P. (1997). Professionalism and medicine. In J. Broadbent, M. Dietrich & J. Roberts (Eds.), *The end of the professions? The restructuring of professional work*. (pp. 69-85). London: Routledge.
- Fagan, R., & Webber, M. (1995). *Global restructuring: The Australian experience*. Oxford: Oxford University Press.
- Feldman, M., Bell, J., & Berger, M. (Eds.). (2003). *Gaining access: A practical and theoretical guide for qualitative researchers*. Walnut Creek, Ca.: Alta Mira Press.
- Femia, J. (2002). Hegemony and consciousness in the thought of Antonio Gramsci. In J. Martin (Ed.), *Antonio Gramsci: Critical assessments of leading political philosophers* (pp. 263-286). London: Routledge.
- Finch, J. (1983). *Married to the job: Wives' incorporation in men's work*. London: George, Allen and Unwin.
- Fleming, J., McRae, C., & Tegen, S. (2001, March 4-7). *From the ground up - successful models of community capacity building to address recruitment and retention of GPs in rural South Australia*. Paper presented at the 6th National Rural Health Conference, Canberra.
- Forgacs, D. (Ed.). (1988). *A Gramsci reader: Selected writings 1916-1935*. London: Lawrence and Wishart.
- Fowlkes, M. (1980). *Behind every successful man: Wives of medicine and academe*. New York: Columbia University Press.
- Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd, Mead and Company.
- Frost, C. (2002, 9-13 June). *General Practice: What, where, when, why and how the experience could be improved. A summary report*. Paper presented at the WONCA Europe, ESGP/FM Conference, London, UK.
- Gabbard, G., Menninger, R., & Coyne, L. (1987). Sources of conflict in the medical marriage. *American Journal of Psychiatry*, 144(5), 567-572.
- Game, A., & Pringle, R. (1983). *Gender at work*. Sydney: George, Allen and Unwin.

- Garden, D. (1977). *Albany: A panorama of the Sound from 1827*. Melbourne: Nelson.
- General Practice Strategic Policy Development Unit. (2000). *General practice in Australia 2000*. Canberra: Australian Government Department of Health and Ageing.
- Germov, J. (2003a). Challenges to medical dominance. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (2nd ed., pp. 283-305). Melbourne: Oxford University Press.
- Germov, J. (2003b). Imagining health problems as social issues. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (pp. 3-27). Melbourne: Oxford University Press.
- Giddens, A. (1986). *The constitution of society*. Berkeley: University of California Press.
- Gramsci, A. (1999). *Selections from the prison notebooks* (Q. Hoare & G. N. Smith, Trans.). New York: International Publishers.
- Gray, I., & Lawrence, G. (2001). *A future for regional Australia: Escaping global misfortune*. Cambridge: Cambridge University Press.
- Great Southern Development Commission. (2003). *Great Southern economic perspective: An update on the economy of Western Australia's Great Southern region*. Perth, WA: Department of Local Government and Regional Development.
- Green, J. (1993). The views of single-handed general practitioners: A qualitative study. *British Medical Journal*, 307(6904), 607-611.
- Hafferty, F., & Light, D. (1995). Professional dynamics and the changing nature of medical work. *Journal of Health and Social Behaviour*, 36, 132-153.
- Hakim, C. (1995). Five feminist myths about women's employment. *British Journal of Sociology*, 4(3), 428-455.
- Hakim, C. (2003a). Competing family models, competing social policies. *Family Matters*, 64(Autumn), 52-61.
- Hakim, C. (2003b). *Models of the family in modern societies: Ideals and realities*. Aldershot, Hants: Ashgate.
- Hall Yandoli, A. (1989). Stress and medical marriages. *Stress Medicine*, 5, 213-219.
- Halliday, J., & Little, J. (2001). Amongst women: Exploring the reality of rural childcare. *Sociologica Ruralis*, 41(4), 423-436.
- Hamilton, C. (2001). Putting doctors where they are needed. *The Australian Institute Newsletter*, 27.
- Hamilton, C. (2003). *Growth fetish*. Sydney: Allen and Unwin.
- Hammersley, M. (1990). *Reading ethnographic research: A critical guide*. London: Longman.
- Hammersley, M. (1992). *What's wrong with ethnography?* London: Routledge.

- Hammersley, M., & Atkinson, P. (1995). *Ethnography; principles in practice* (2nd ed.). London: Routledge.
- Hand, K., & Lewis, V. (2002). Fathers' views on family life and paid work. *Family Matters*, 61(Autumn), 26-29.
- Haslam McKenzie, F. (2000). Where do people fit in the rural equation? In B. Pritchard & P. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 73-89). Sydney: University of New South Wales.
- Hawthorne, L., & Birrell, B. (2002). Doctor shortages and their impact on the quality of medical care in Australia. *People and Place*, 10(3), 55-67.
- Hays, R. (1999). Common international themes in rural medicine. *Australian Journal of Rural Health*, 7, 191-194.
- Hays, R., Wynd, S., Veitch, C., & Crossland, L. (2003). Getting the balance right? GPs who choose to stay in rural practice. *Australian Journal of Rural Health*, 11, 193-198.
- Hegney, D., & McCarthy, A. (2002). Preparation for rural nursing practice. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 237-252). Melbourne: Oxford University Press.
- Hindess, B. (1998). Neoliberalism and the national economy. In M. Dean & B. Hindess (Eds.), *Governing Australia* (pp. 210-226). Cambridge: Cambridge University Press.
- Hirsch, N., & Fredericks, C. (2001, 4-7 March). *Rural doctors and retention*. Paper presented at the 6th National Rural Health Conference, Canberra.
- Hochschild, A. (1989). *The second shift: Working parents and the revolution at home*. New York: Viking.
- Hochschild, A. (2003). *The commercialization of intimate life: Notes from home and work*. Berkeley, California: University of California Press.
- Holub, L., & Williams, B. (1996). The general practice Rural Incentives Program, development and implementation: Progress to date. *Australian Journal of Rural Health*, 4, 117-127.
- Humphreys, J. (1985). A political economy approach to the allocation of health care resources: The case of remote areas of Queensland. *Australian Geography Studies*, 23(2), 222-242.
- Humphreys, J. (1998). Delimiting 'rural': implications of an agreed rurality index for healthcare planning and resource allocation. *Australian Journal of Rural Health*, 6(4), 212-216.
- Humphreys, J., Jones, J., Jones, M., Hugo, G., Bamford, E., & Taylor, D. (2001). A critical review of rural medical workforce retention in Australia. *Australian Health Review*, 24(4), 91-102.
- Humphreys, J., & Rolley, F. (1998). A modified framework for rural general practice: The importance of recruitment and retention. *Social Science and Medicine*, 46(8), 939-945.

- Incitti, F., Rourke, L., Rourke, J., & Kennard, M. (2003). Rural women family physicians: Are they unique? *Canadian Family Physician*, 49(March), 320-327.
- Jenkins, R. (1993). *Pierre Bourdieu*. London: Routledge.
- Johnson, L. (1989). The guns of King George's Sound: The Albany forts. Albany, WA: Albany Advertiser.
- Johnson, L. (2001). *Albany: Who and what?* Albany, WA: Western Australian Museum.
- Jones, J. A., Humphreys, J. S., & Adena, M. (2004). Doctors' perspectives on the viability of rural practice. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*, 4(online)(305).
- Joyce, C., McNeil, J., & Stoelwinder, U. (2004). Time for a new approach to medical workforce planning. *Medical Journal of Australia*, 180(7), 343-346.
- Kamien, M. (1987). *Report of the ministerial inquiry into the recruitment and retention of country doctors in Western Australia*. Perth: University of Western Australia.
- Kamien, M. (1998). Staying in or leaving rural practice: 1996 outcomes of doctors' 1986 intentions. *Medical Journal of Australia*, 169, 318-321.
- Keleher, H. (1999). Rural public health matters. *Australia and New Zealand Journal of Public Health*, 23(4), 242-245.
- Keyzer, D. (1997). Working together: The advanced rural nurse practitioner and the rural doctor. *Australian Journal of Rural Health*, 5, 184-189.
- Kilmartin, M., Newell, C., & Line, M. (2002). The balancing act: Key issues in the lives of women general practitioners in Australia. *Medical Journal of Australia*, 177(15 July), 87-89.
- Komter, A. (1989). Hidden power in marriage. *Gender and Society*, 3(2), 187-216.
- Krais, B. (1993). Gender and symbolic violence: Female oppression in the light of Pierre Bourdieu's theory of social practice. In C. Calhoun, E. LiPuma & M. Postone (Eds.), *Bourdieu: Critical perspectives* (pp. 156-177). Cambridge: Polity.
- Kuhlmann, E. (2002, 2-4 May). *Post-modern times for professions: Theoretical issues and empirical evidence from the field of health care*. Paper presented at the Research Network Sociology of Professions in the ESA, Second Interim Workshop, Paris.
- Lapeyre, N. (2003). Professional and domestic work arrangements of women general practitioners in France. *International Journal of Sociology and Health Policy*, 23(4/5), 97-122.
- Larson, A. (2002). Contemporary rural Australian society. In D. Wilkinson & I. Blue (Eds.), *The New Rural Health* (pp. 3-11). Oxford: OUP.
- Latham, M. (1994). A third way: Beyond incremental reform of the Australian health economy. *Australian Health Review*, 17(4), 34-62.

- Laven, G., & Wilkinson, D. (2003). Rural doctors and rural backgrounds: How strong is the evidence? A systematic review. *Australian Journal of Rural Health*, 11, 277-284.
- Lawrance, R. (2001, 4-7 March). *What symbolises rural and remote general practice: The practitioners' perspective*. Paper presented at the Sixth National Rural Health Conference, Canberra, ACT.
- Lechte, J. (1996). *Fifty key contemporary thinkers: From structuralism to postmodernity*. London: Routledge.
- Leese, B., & Young, R. (1999). *Disappearing GPs: Is there a crisis in recruitment and retention of general practitioners in England?*. Manchester: National Primary Care Research and Development Centre.
- Lippert, N. (1991, 14-16 February). *The spouses: A major support for the rural doctor*. Paper presented at the First National Rural Health Conference, Toowoomba, Queensland.
- Lippert, N., & Tolhurst, H. (2001, September). *Female rural GPs: Findings of the National Female Rural GP Research Project*. Paper presented at the 44th RACGP Scientific Convention, Sydney.
- Little, J. (1997). Employment marginality and women's self-identity. In P. Cloke & J. Little (Eds.), *Contested countryside cultures: Otherness, marginalisation and rurality* (pp. 138-157). London: Routledge.
- Lockie, S. (2000). Crisis and conflict: shifting discourses or rural and regional Australia. In B. Pritchard & P. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 14-32). Sydney: University of New South Wales.
- Lupton, D. (2000). *Medicine as culture: Illness, disease and the body in Western societies*. London: Sage.
- Lyle, D. (2002). Infrastructure and support for rural practitioners. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 260-272). Oxford: Oxford University Press.
- MacIsaac, P., Snowden, T., Thompson, R., Crossland, L., & Veitch, C. (2000). General practitioners leaving rural practice in Western Victoria. *Australian Journal of Rural Health*, 8, 68-72.
- MacKinnon, C. (1997). Feminism, Marxism, method and state. In D. Tietjens Myers (Ed.), *Feminist social thought: A reader* (pp. 64-92). New York: Routledge.
- Maginn, P. (forthcoming). Negotiating and securing access: Reflections on an ethnographic study into urban regeneration, community power and 'race' in the UK.
- Maher, L. (2001). Rural Retention. *GP Review*, 5(10), online. Retrieved June 5, 2004, from <http://www.racgp.org.au/document.asp?id=4196>
- Maushart, S. (2001). *Wifework: What marriage really means for women*. Melbourne: The Text Publishing Company.

- McAvoy, B. (2000-2001). Models of primary health care: The UK experience. *New Doctor*(74, summer), 9-12.
- McKenzie, F. (2003). Regional skills shortages: An overview of demographic, economic and social change. *Sustaining Regions*, 3(1), 5-15.
- McKevitt, C., & Morgan, M. (1997). Anomalous patients: The experiences of doctors with an illness. *Sociology of Health and Illness*, 19(5), 644-667.
- McKinlay, J. B., & Arches, J. (1985). Towards the proletarianization of physicians. *International Journal of Health Services*, 15, 161-195.
- McKinlay, J. B., & Marceau, L. (2002). The end of the golden age of doctoring. *International Journal of Health Services*, 32(2), 379-416.
- McMahon, A. (1998). Blokus domesticus: The sensitive new age guy in Australia. *Journal of Australian Studies*, 56, 147-157.
- Melleuish, G. (1997). Living in an age of packages: "Economic rationalism" and "the clever country" in Australian political thought. *Australian Journal of Politics and History*, 43(2), 200-213.
- Miles, J., Krell, R., & Tsung-Yi, L. (1975). The doctor's wife: Mental illness and marital pattern. *International Journal of Psychiatry in Medicine*, 6(4), 481-487.
- Miles, R., Marshall, C., Rolfe, J., & Noonan, S. (2004, February 19). *The attraction and retention of professionals to regional areas*. Paper presented at the Bureau of Transport and Regional Economics Inaugural National Regional Research Colloquium, Canberra.
- Mills, I. (1997). Recruiting general practitioners to rural areas: One community's experience. *Australian Journal of Rural Health*, 5, 194-197.
- Murphy, R. (1971). *The dialectics of social life: Alarms and excursions in anthropological theory*. London: Basic Books Inc.
- Nader, L. (1972). Up the anthropologist: Perspectives gained from studying up. In D. Hymes (Ed.), *Reinventing anthropology* (pp. 284-311). New York: Pantheon.
- National Rural Health Alliance. (2004). PARTYline goes to the polls. *PARTYline: National Rural Health Alliance Inc*, May, 10-11. Retrieved July 23, 2004, from <http://www.ruralhealth.org.au/nrhpublic/Index.cfm?Category=PartyLine>
- National Rural Health Policy Forum, & National Rural Health Alliance. (1999-2003). *Healthy horizons*. Canberra: Department of Health and Aged Care, Australian Health Ministers Conference.
- Nelson, S. (1978). Some dynamics of medical marriages. *Journal of the Royal College of General Practitioners*, 28, 585-586.
- Nichols, A. (1997, 9-12 February.). *The spouses of rural doctors: A significant influence on professional life in the bush*. Paper presented at the 4th National Rural Health Conference, Perth, Western Australia.

- Nord, E., Richardson, J., Street, A., Kuhse, H., & Singer, P. (1995). Maximizing health benefits vs egalitarianism: An Australian survey of health issues. *Social Science & Medicine*, 41(10), 1429-1437.
- Oakley, A. (1985). *The sociology of housework*. Oxford: Basil Blackwell.
- O'Reilly, M. (1997). Medical recruitment in rural Canada: Marathon breaks cycle. *Canadian Medical Association Journal*, 156(11), 1593-1596.
- Ortner, S. (1989). *High religion: A cultural and political history of Sherpa Buddhism*. Princeton: Princeton University Press.
- Palmer, G., & Short, S. (2000). *Health care and public policy: An Australian analysis* (3rd ed.). Melbourne: Macmillan.
- Pearson, A. (1993, 12-14 February). *Expansion and extension of rural health workers' roles to increase access to health services in rural areas*. Paper presented at the 2nd National Rural Health Conference, University of New England, Armidale, NSW.
- Peck, J., & Tickell, A. (1994). Jungle law breaks out: Neoliberalism and global-local disorder. *Area*, 26(4), 317-326.
- Phelps, K. (2002). *AMA President, Media Conference, Canberra*. Retrieved March 16, 2004, from <http://www.ama.com.au/web.nsf/doc/SHED-5EXHQV>
- Phillips, A. (2005). *Rural, regional and remote health: Indicators of health*. Canberra: Australian Institute of Health and Welfare.
- Pringle, R. (1997). Feminist theory and the world of the social. *Current Sociology*, 45(2), 1-6.
- Pringle, R. (1998). *Sex and medicine: Gender, power and authority in the medical profession*. Cambridge: Cambridge University Press.
- Rabinowitz, H., Diamond, J., Hojat, M., & Hazelwood, C. (1999). Demographic, educational and economic factors related to the recruitment and retention of physicians in rural Pennsylvania. *Journal of Rural Health*, 15(2), 212-218.
- Rees, S. (1994). Economic rationalism: An ideology of exclusion. *Australian Journal of Social Issues*, 29(2), 171-185.
- Rhodes, L. (2001). *Two for the price of one: A qualitative study of the lives of mining wives*. Unpublished PhD thesis, Curtin University of Technology, Perth, Western Australia.
- Rice, P., & Ezzy, D. (2001). *Qualitative research methods: A health focus*. Oxford: Oxford University Press.
- Richards, A., Carley, J., Jenkins-Clarke, S., & Richards, D. A. (2000). Skill mix between nurses and doctors working in primary care-delegation or allocation: A review of the literature. *International Journal of Nursing Studies*, 37, 185-197.
- Riska, E., & Weagar, K. (1993). Women physicians: A new force in medicine? In E. Riska & W. K (Eds.), *Gender, work and medicine: Women and the medical division of labour* (pp. 77-94). London: Sage.

- Roach, S. (2002). *Female general practitioners in remote and rural Western Australia*. Perth: Western Australian Centre for Remote and Rural Medicine.
- Roach, S. (2003). *Overseas trained doctors: The WACRRM program 1999-2002*. Perth: Western Australian Centre for Rural and Remote Medicine (WACRRM).
- Rodger, J. (2000). *From a welfare state to a welfare society: The changing context of social policy in a postmodern era*. London: Macmillan's Press Ltd.
- Rural Doctors' Association of Australia. (2003a). *Geographic provider numbers*. Retrieved June 10, 2004, from <http://www.rdaa.com.au/default.cfm?action=publications>
- Rural Doctors' Association of Australia. (2003b). *Viable models for rural and remote practice: stage 1 and stage 2 report*. Canberra: RDAA.
- Sakinofsky, I. (1980). Suicide in doctors and wives of doctors. *Canadian Family Physician*, 26(June), 837-844.
- Sarantakos, S. (1998). *Social research*. Melbourne: Macmillan Education.
- Scholte, B. (1972). Toward a reflexive and critical anthropology. In D. Hymes (Ed.), *Reinventing anthropology* (pp. 430-458). New York: Pantheon.
- Scott, M., Whelan, A., Dewdney, J., & Zwi, A. (2004). "Brain drain" or ethical recruitment? Solving health workforce shortages with professionals from developing countries. *Medical Journal of Australia*, 180, 174-176.
- Sevier, K. (1990). *Spouse discussion group*. Paper presented at the Rural Doctors' Association Second Annual Conference, Coff's Harbour, NSW.
- Sexton, R. (2002, 22-24 April). *The Dr. DOC program: A South Australian rural GP health and wellbeing initiative of the Rural Doctors' Workforce Agency, South Australia*. Paper presented at the Australian Rural and Remote Workforce Agencies (ARRWAG) Conference, Adelaide.
- Shaffir, W., & Stebbins, R. (Eds.). (1991). *Experiencing fieldwork: An inside view of qualitative research*. London: Sage.
- Sibbald, B., & Young, R. (2001). *The general practitioner workforce 2000. Workload, job satisfaction, recruitment and retention*. Manchester: National Primary Research and Development Centre, University of Manchester.
- Siegloff, L. (1995). The nurse practitioner project, Wilcannia: Moving from anecdotes to evidence. *Australian Journal of Rural Health*, 3, 114-121.
- Simon, R. (1982). *Gramsci's political thought: An introduction*. London: Lawrence and Wishart.
- Singer, M. (1990). Reinventing medical anthropology: Toward a critical realignment. *Social Science and Medicine*, 30(2), 179-187.
- Singer, M., & Baer, H. (1995). *Critical medical anthropology*. Amityville, New York: Baywood Publishing Co Inc.

- Smailes, P. (1995). The enigma of sustainability of rural Australia. *Australian Geographer*, 26(2), 140-150.
- SMEC Australia Pty. Ltd. (2002). *Ravensthorpe/Esperance and Jerramungup strategic blueprint for the future*. Perth, WA: SMEC Australia Pty. Ltd.
- Smith, K., Humphreys, J., Lenard, Y., Jones, J., Prince, V., & Han, G.-S. (2004). Still the doctor - by a country mile! Preferences for health services in two country towns in north-west New South Wales. *Medical Journal of Australia*, 181(2), 91-95.
- Snadden, D. (1993). Leaving practice: General practitioners who decide to leave their practice. How to do it. *British Medical Journal*, 306(6894), 1740-1743.
- South West People Care. (2002). Shire of Jerramungup, (Draft 2) Strategic Plan 2002-2007. Busselton, WA: South West People Care.
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rhinehart, Winston.
- Steil, J. (1997). *Marital equality; its relationship to the wellbeing of husbands and wives*. Thousand Oaks: Sage.
- Strasser, R., Hays, R., Kamien, M., & Carson, D. (2000). Is Australian rural practice changing? Findings from the national rural general practice study. *Australian Journal of Rural Health*, 8, 222-226.
- Strasser, R., Kamien, M., & Hays, R. (1997). *National rural general practice study* (No. GPEP 465). Melbourne: Monash University, Centre for Rural Health.
- Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, California: Sage.
- Strong, K., Trickett, P., Titulaer, I., & Bhatia, K. (1998). *Health in rural and remote Australia* (No. PHE 6). Canberra: AIHW.
- Sullivan, O. (2000). The division of domestic labour: Twenty years of change? *Sociology*, 34(3), 437-456.
- Summers, A. (2003). *The end of equality: Work, babies and women's choices in 21st century Australia*. Sydney: Random House.
- Sutherland, V., & Cooper, C. (1992). Job stress, satisfaction and mental health among general practitioners before and after the introduction of new contract. *British Medical Journal*, 304(6841), 1545-1549.
- Tavris, C. (1992). *The mismeasure of woman*. New York: Simon and Schuster.
- Tedlock, B. (2000). Ethnography and ethnographic representation. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 455-486). Thousand Oaks, California: Sage.
- Tichenor, V. (1999). Status and income as gendered resources: The case of marital power. *Journal of Marriage and the Family*, 61(3), 638-650.

- Tonts, M. (2000). The restructuring of Australia's rural communities. In B. Pritchard & F. McManus (Eds.), *Land of discontent: the dynamics of change in rural and regional Australia* (pp. 52-72). Sydney: University New South Wales.
- Tonts, M. (2004). Spatially uneven development: Government policy and rural reform in the Wheatbelt of Western Australia. *Anthropological Forum*, 14(3), 237-252.
- Turner, B. (1997). From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. In A. Petersen & R. Bunton (Eds.), *Foucault: Health and medicine* (pp. vix-xxi). London: Routledge.
- Twaddle, A. (1996). Health system reforms: Toward a frame for international comparison. *Social Science and Medicine*, 43(5), 637-654.
- Van den Berg, R. (2002). *Nyoongar people of Australia*. Leiden: Brill.
- Van der Weyden, M. (2001). Australian general practice at a fork in the road: Which way forward? *Medical Journal of Australia*, 175, 62-63.
- Van Maanen, J. (1988). *Tales of the field: On writing ethnography*. Chicago: University of Chicago Press.
- Veitch, C., Harte, J., Hays, R., Pashen, D., & Clark, S. (1999). Community participation in the recruitment and retention of rural doctors: Methodological and logistical considerations. *Australian Journal of Rural Health*, 7, 206-211.
- Wainer, J. (2000). Women and rural medical practice. *South African Family Practice Journal*, 22(6), 19-23.
- Wainer, J. (2001). *Victorian rural women practitioner survey*. Melbourne: Rural Workforce Agency of Victoria.
- Wainer, J. (2002). *New voices in rural medical practice: Analysis of qualitative data from the national rural general practice study*. Melbourne and Canberra: Monash University, Commonwealth Department of Health and Ageing.
- Wainer, J. (2003). Gender and the medical curriculum: A rural case study. *Women and Health*, 37(4), 67-87.
- Wainer, J. (2004). Work of female rural doctors. *Australian Journal of Rural Health*, 12, 49-53.
- Wainer, J., Bryant, L., & Strasser, R. (2001). Sustainable rural practice for female general practitioners. *Australian Journal of Rural Health*, 9 (suppl.), S43-S48.
- Wainer, J., Bryant, L., Strasser, R., Carson, D., & Stringer, K. (1999, 14-17 March). *A life, not a wife*. Paper presented at the 5th National Rural Health Conference, Adelaide, South Australia.
- Wainer, J., Strasser, R., & Bryant, L. (2005, 10-13 March). *Strengthening the rural medical workforce: Understanding gender*. Paper presented at the 8th National Rural Health Conference, Alice Springs, Northern Territory.

- Walker, S. (1963). *History of hospital services in Albany, WA*. Albany, WA: Albany Public Library and Information Service: Local Studies Collection.
- Wearne, S., & Wakerman, J. (2004). Editorial: Training our future rural medical workforce. *Medical Journal of Australia*, 180, 101-102.
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Sydney: Allen and Unwin.
- West, C., & Zimmerman, D. (1987). Doing gender. *Gender and Society*, 1(2), 125-151.
- Western Australian Centre for Remote and Rural Medicine. (2003). *WACRRM annual review*. Perth: University of Western Australia.
- White, C., & Fergusson, S. (2001). *Discussion paper: Female medical practitioners in rural and remote Queensland: An analysis of findings, issues and trends*. Brisbane: Queensland Rural Medical Support Agency.
- White, K. (2000a). The state, the market and general practice: The Australian case. *International Journal of Health Services*, 30(2), 285-308.
- White, K. (2000b). What's happening in general practice: Capitalist monopolisation and state administrative control: a profession bailing out? *Annual Review of Health Social Sciences*, 10(1), 5-18.
- White, K. (2002). *An introduction to the sociology of health and illness*. London: Sage.
- Wicks, D. (2002). Nursing and sociology. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (2nd ed., pp. 306-324). Melbourne: Oxford University Press.
- Williams, R. (1994). Selections from Marxism and literature. In N. Dirks, G. Eley & S. Ortner (Eds.), *Culture, power and history: A reader in contemporary social theory* (pp. 585-608). Princeton: Princeton University Press.
- Willis, E. (1989). *Medical dominance* (revised ed.). Sydney: Allen and Unwin.
- Winefield, H. (2003). Work stress and its effects in general practitioners. In M. Dollard, A. Winefield & H. Winefield (Eds.), *Occupational stress in the service professions* (pp. 191-212). London: Taylor and Francis.
- Wise, A., Nichols, A., Chater, A., & Craig, M. (1996). *Rural doctors' spouses: Married to the practice?* Brisbane: Queensland Medical Education Centre.
- Witz, A. (1992). *Professions and patriarchy*. London: Routledge.
- Wolcott, H. (2001). *Writing up qualitative research* (2nd ed.). Thousand Oaks: Sage.
- Worley, P. (2004). Always one doctor away from a crisis! *Rural and Remote Health (online)*, 4(317), 1-3.
- Yalom, M. (2001). *A history of the wife*. London: Pandora.

Young, R., Leese, B., & Sibbald, B. (2001). Imbalances in the GP labour market in the UK: Evidence from a postal survey and interviews with GP leavers. *Work, Employment and Society*, 15(4), 699-719.

## Appendix 1a

Dr  
Chair,  
GSDGP

Dear Dr \_\_\_\_\_,

**Re: Study of factors affecting the wellbeing of GPs and their families in rural and remote WA**

You may recall that we met at the dinner following the GSDGP Continuing Professional Development day in November last year. I am happy to report that we are moving closer towards the data gathering phase. I wonder if I could take you up on your offer to read through and comment on the attached documents which I hope to send out to all GPs and their spouses/partners in the GSDGP inviting them to participate in the study. It would be helpful if I can enclose a letter from you. With this in mind, I have taken the liberty of drafting a letter for your consideration and possible amendment which I would be grateful if you would sign and return to me or drop it off with Mary MacNish at the Division.

I look forward to hearing from you.

Many thanks

Sincerely,

Angela Durey  
PhD Candidate  
Centre for Social Research  
Ph 08 6304 5162  
Email: [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

Chair

Great Southern Division of General Practice

Dear Colleagues and Spouses/Partners,

**Re: Study of factors affecting the wellbeing of GPs and their families  
in rural and remote WA**

Some of you might recall the Professional Development day in November 2002 where Angela Durey, a PhD candidate from the Centre for Social Research at Edith Cowan University, presented a proposal for her research on the above topic focusing on GPs and their families in the GSDGP. This is a project that has the support of the Australian Research Council, Edith Cowan University and The Great Southern Division of General Practice. Given the current relevance of issues related to the recruitment and retention of GPs and their families in rural and remote areas, I would encourage you and your partners/spouses to support this study by participating in the project.

Further information about the study and relevant contact details are attached.

Yours Sincerely

Dr \_\_\_\_\_

Chair

GSDGP

## **Appendix 1b**

### **Study of the wellbeing of rural GPs and their families**

Dear

I am writing to invite you to participate in an important research project that is supported by the Australian Research Council (ARC), Edith Cowan University (ECU), and the Great Southern Division of General Practice (GSDGP).

#### **Why is this study important?**

Some studies over the years have examined factors affecting recruitment and retention of GPs in rural and remote Australia. Recommendations have been suggested, some have been implemented, yet problems persist. This project is designed to cover areas not part of previous studies, including the responses and experiences of both GPs and their spouses/partners, a broader range of issues underpinning wellbeing and the decision to stay or leave rural practice in rural WA, and the impact of changes in government policy and community expectations. It is hoped this approach will provide a deeper understanding of issues affecting the recruitment and retention of rural GPs and their families with a view to creating some innovative solutions to the problems.

#### **Why is your help needed?**

The success of this research depends on your participation. It is hoped that insights generated from the project will inform the development of health policies and strategies aimed at improving health care provision generally in rural and remote communities. Results of the study may be shared with GPs and their spouses/partners involved in the project, though access to personal data will not be available to anyone other than myself so your confidentiality is assured. You will not be identified in any report resulting from this study.

#### **What next?**

This letter is being sent to all GPs and their spouses/partners in the GSDGP and a selected number who have worked or are currently working in a rural or remote area. I have attached an information sheet to introduce myself and explain what is involved. If you have any questions or would like further information, please feel free to either phone or email me. I will contact you again by phone in the hope that you will agree to participate in this important project at a time and place that is convenient to you.

Sincerely,

Angela Durey  
Centre for Social Research  
Ph : 08 6304 5162  
GSDGP  
08 9842 2797  
Email: [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

## Appendix 1c

### Information Sheet

Edith Cowan University (ECU) and the Great Southern Division of General Practice (GSDGP) are collaborating in research to identify issues related to the wellbeing of GPs and their spouses/partners living and working in rural and remote areas. The project aims to address problems associated with the diminishing number of GPs and how that affects health care provision in rural communities. The research will help the GSDGP to contribute to the debate and formation of public policy in issues related to rural health. This will include suggesting strategies to attract and retain GPs and their families to live and work in rural and remote areas and to improve the quality of health and medical services available in these locations.

Previous studies have shown that declining medical services in these areas have often led to GPs feeling overworked, stressed and frustrated at the demands placed on them and the effects of these on family life and leisure time. Spouses/partners also experience the effects of these demands along with, often, heightened community expectations of being the doctor's spouse. This proposed research is the first of its kind to be undertaken in Australia involving both GPs and their spouses/partners. It acknowledges the significant role that spouses/partners may play in the decision for the family to remain in or leave a rural community. It also seeks to understand the challenges you both face and the extent to which you think these problems can be improved including examining possible innovative solutions.

I am a PhD candidate at Edith Cowan University. This research will form part of my final dissertation. I hope at least 20 GPs and their spouses/partners will agree to participate. The project will involve my spending some time with you and your spouse/partner in the community in which you live to find out about the challenges, difficulties and positive aspects of living and working in a rural or remote area. This will include conducting interviews with each of you on your experiences in this context and their effects on your sense of wellbeing and your desire to stay or leave. In order to gain a depth of understanding of your experiences and to offer you the opportunity to speak about them and your views on issues related to the project, the interviews may last up to 2 hours. Where this is not possible, you may prefer to conduct a series of shorter interviews. I will do my best to fit in with what is most convenient for you. Topics for discussion will include the relationship between the demands of work on home life, the experiences of doctors and their families at different life stages or with different prior knowledge of rural life in Western Australia, the experiences and expectations of overseas trained doctors and their families and the impact on rural general practice of changes in government policy and community expectations.

I hope you'll enjoy taking part in the research and find it interesting. If you have any queries about the project or would like to discuss related concerns, please contact Angela Durey at ECU on 08 6304 5162, the Division on 08 9842 2797 or email [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au). If you have any unresolved concerns, please contact Associate Professor Sherry Siggers, Director, Centre for Social Research, Edith Cowan University, Joondalup, WA 6027 Phone 08 6304 5074 who is independent from the research team.

Thank you. Your assistance is much appreciated.

## Appendix 2a

GSDGP Newsletter article August 2003

### Study of the wellbeing of rural GPs and their families

This important research project is supported by the Australian Research Council, Edith Cowan University, and the Great Southern Division of General Practice. Various studies over the years have examined factors affecting recruitment and retention of GPs in rural and remote Australia. Recommendations have been suggested, some have been implemented, yet problems persist.

Declining medical services in these areas have often led to GPs feeling overworked, stressed and frustrated at the demands placed on them and the effects of those demands on their own health, family life and leisure time. Spouses/partners also experience the effects of these demands along with, often, heightened community expectations of being the doctor's spouse.

This project is designed to acknowledge these effects and to cover areas not part of previous studies, including the responses and experiences of both GPs and their spouses/partners, a broader range of issues underpinning wellbeing and the decision to stay or leave rural practice in rural WA, and the impact of changes in government policy and community expectations.

The project aims to address problems associated with the diminishing number of GPs and how that affects health care provision in rural communities. It is hoped this approach will provide a deeper understanding of issues affecting the recruitment and retention of rural GPs and their families with a view to improving the situation and creating some innovative solutions to the problems.

#### What is involved?

The success of this research depends on the participation of GPs and their spouses/partners in the GSDGP. The research will be conducted by Angela Durey, a PhD candidate at the Centre for Social Research, Edith Cowan University who lived in a rural area in the UK and Australia for many years as the spouse of a GP and has four grown up children. She originally trained as a State Registered Nurse in the UK, has an Honours degree in Anthropology and a Masters degree in Applied Anthropology. She will spend several months in the Great Southern from July and will contact all GPs and their spouses/partners in the region inviting them to participate in the project.

Part of her research will involve conducting interviews with GPs and their spouses/partners that will include topics relating to their experiences living and working in a rural or remote area, its effects on a sense of wellbeing and factors influencing the desire to stay or leave rural practice. It is hoped that insights generated from the project will inform the development of health policies and strategies aimed at improving health care provision generally in rural and remote communities.

For more information please contact Angela Durey 08 6304 5162 or 08 9842 2797 (from end of July) or email [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

## GSDGP Newsletter article November 2005

I recently spent several months in the GSDGP travelling around the region as part of my PhD project. My aim was to meet and interview interested GPs and spouses/partners on factors affecting their wellbeing living and working in rural areas. Initial contact was made by sending information explaining the project to all GPs and their spouses/partners in the Division which was followed up by visits to every general practice in the GSDGP to arrange interviews with those interested in being involved. I contacted spouses/partners mainly through the GPs as accessing private phone numbers was difficult given confidentiality issues. I interviewed 21 spouses and 32 GPs (about 48% including registrars) with some agreeing to be interviewed twice and three times.

I am currently in the process of collating and analysing the information gathered. First impressions suggest the need to problematise the notion of 'rural' to adequately reflect the diversity inherent in the term by dividing 'rural' into regional centre, large rural centre with several GPs in group practices and small rural town serviced by solo GPs. This will help provide a framework to understand some of the factors affecting wellbeing of GPs and spouses living in these areas. Another impression from the interviews is that, while it may be difficult to recruit GPs to work in rural areas, retention seemed less of a problem with the majority of GPs and their spouses enjoying living in the country with plans to remain there rather than return to the city.

I would like to take this opportunity to thank everyone involved in the project for the time that you gave and your willingness to be interviewed. It was a pleasure to meet you and the depth and candour with which you shared your experiences, ideas, thoughts and comments were much appreciated. I look forward to collating and analysing the information which will extend the current debate on issues related to recruitment and retention of GPs and their families in rural areas.

## Appendix 3

### Consent form

Title of Project: A sociological study of the factors affecting the wellbeing of general practitioners and their spouses in rural and remote WA

Researcher

*Angela Durey, PhD Candidate, Centre for Social Research, School of International Cultural and Community Studies Faculty of Community Services, Education and Social Sciences, Edith Cowan University, Joondalup, Western Australia 6027*

I.....have read the information on the Information Sheet and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity realising that I may withdraw at any time.

I understand that all information provided is treated as strictly confidential and will not be released by the researcher unless required to do so by law.

I agree that research data gathered for this study may be published provided my name or other identifying information is not used.

I agree that the researcher can audio-tape this interview on the understanding that, following the completion of the project, including the submission of subsequent papers for publication, the data on the tape are deleted and transcripts and other records of interviews, destroyed

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

For further information or questions, please contact Angela Durey, ph 08 6304 5162. If you have any unresolved concerns please contact Associate Professor Sherry Saggars, Director, Centre for Social Research, Edith Cowan University, Joondalup, WA 6027. Ph 6304 5074 who is independent from the research team.



**THE CHANGING FACE OF RURAL  
GENERAL PRACTICE: AN ETHNOGRAPHIC  
STUDY OF GENERAL PRACTITIONERS AND  
THEIR SPOUSES**

by

Angela Durey MAA BA (Hons)

Thesis submitted in fulfilment of the requirements for the degree of  
Doctor of Philosophy  
in  
Anthropology and Sociology  
Faculty of Community Services, Education and Social Sciences  
Edith Cowan University (December, 2005).

## USE OF THESIS

*This copy is the property of Edith Cowan University. However, the literary rights of the author must also be respected. If any passage from this thesis is quoted or closely paraphrased in a paper or written work prepared by the user, the source of the passage must be acknowledged in the work. If the user desires to publish a paper or written work containing passages copied or closely paraphrased from this thesis, which passages would in total constitute an infringing copy for the purpose of the Copyright Act, he or she must first obtain the written permission of the author to do so.*

## **ABSTRACT**

‘Rural general practice is general practice at its best’: a comment by one GP interviewed for this study was echoed by colleagues who viewed their work in a rural setting as challenging, diverse, rewarding and satisfying. Despite reported difficulties associated with rural general practice, many GPs argued that the benefits outweigh the disadvantages. Few wanted to leave. Nonetheless, too few Australian trained GPs are willing to move from cities to work in the country. Consequently, overseas trained doctors have been recruited to fill vacancies or nurses provide health services in communities unable to attract a GP.

This thesis adds to findings of previous studies by critically examining structural issues affecting decisions made by GPs and their spouses to work in country areas. First, it discusses the impact of gender as a structural force on the expectations and experiences of rural GPs and their spouses, a theme rarely considered in studies on recruitment and retention. Increasing numbers of women are entering the medical profession and wanting changes to inflexible work patterns. Many prefer working fewer hours to balance the demands of medical practice and family, an option also favoured by some male GPs. Male spouses of rural GPs are more likely to work in their chosen occupation while female spouses often subordinate their career aspirations to support those of their GP partner. Such issues are considered in the context of providing rural GP services. Second, the study explores how political and economic changes have affected rural general practice. Neoliberal policies focusing on competition and cost effectiveness are driving the allocation of health care resources and impacting on the autonomy and control of rural GPs over their work practices. Governments have increasingly intervened in clinical practice amid calls for accountability and threats from patients of medical litigation. Other health professionals are also competing to provide services once offered exclusively by the medical profession. In the face of such developments, many rural GPs feel uncertain, insecure and frustrated.

Ethnographic methods, including participant observation, in-depth interviews

and informal discussions, are used to identify the behaviour, satisfactions, frustrations and hopes of both Australian trained and overseas trained GPs and their spouses living and working in the area covered by the Great Southern Division of General Practice in rural Western Australia. Few studies have focused on overseas trained doctors' expectations and experiences of rural general practice in Australia. Even though most rural GPs are married or in committed relationships, research on expectations and experiences of GPs' spouses/partners is limited. This project fills the gap.

In analysing the relationship between structural issues and social practice, the thesis builds on the foundational work of Gramsci and Bourdieu and draws also on theoretical insights developed by Connell and others. It focuses on the concept of power to examine how enduring patterns of social relations are either reproduced or contested in a rural general practice setting. The study concludes that critically examining the relationship between structural factors and social practice offers a more nuanced appreciation of the range of influences affecting the lives of rural GPs and their spouses. This leads to the conclusion that, without understanding this relationship, we are likely neither to overcome the difficulties of recruitment and retention, nor to adequately address the broader problems of rural health care.

## DECLARATION

*I certify that this thesis does not, to the best of my knowledge and belief:*

- (i) incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education.*
- (ii) contain any material previously published or written by another person except where due reference is made in the text; or*
- (iii) contain any defamatory material.*

*I also grant permission for the Library at Edith Cowan University to make duplicate copies of my thesis as required.*

Signature: .....

Date: .....

## ACKNOWLEDGEMENTS

This thesis could not have been written without the support of a range of people. First, I extend a sincere thank you to my supervisors, Alan Black, John Duff and Ann-Claire Larsen for their knowledge, insights and experience. I valued their constructive feedback, sound advice, and encouragement to dig deeper and go the distance. Thanks also to Sherry Saggars, Director of the Centre of Social Research at Edith Cowan University for her support throughout the PhD journey and Ann Larson, Director of the Combined Universities Centre for Rural Health for setting me on this road in the first place.

I acknowledge and appreciate the partial funding for this project from the Australian Research Council. My appreciation also goes to the Great Southern Division of General Practice for assisting with the funding and providing support throughout the research. Sincere thanks are also extended to all participants who were involved in this research. I greatly valued their generosity in giving up their time so willingly and the candour with which they related their experiences.

Thank you also to Rose Durey for proof reading the thesis, to Liz Roberts for her comments on various drafts and to my friends, for their unfailing belief in me, their encouragement when I felt like giving up and their understanding when I was unavailable and preoccupied. And thank you to my children and family for their love, support and generosity. They made me realise that life goes on despite the thesis, that humour is vital and that taking myself too seriously is not on the agenda.

# TABLE OF CONTENTS

USE OF THESIS .....	i
ABSTRACT .....	ii
DECLARATION .....	iv
ACKNOWLEDGEMENTS .....	v
TABLE OF CONTENTS .....	vi
LIST OF TABLES .....	xi
LIST OF MAPS .....	xi
FIGURES .....	xii
ABBREVIATIONS AND ACRONYMS .....	xiii
INTRODUCTION .....	1
Rural general practice .....	2
The social practice of gender .....	10
<i>Female rural GPs</i> .....	10
<i>Rural GPs' spouses</i> .....	11
The effects of political and economic change .....	12
<i>Rural centres</i> .....	12
<i>Rural health services</i> .....	13
Purpose of the study .....	15
Areas of enquiry .....	16
Chapter overview .....	16
CHAPTER 1 The changing face of rural general practice: the relationship between structure and social practice .....	19
Hegemony .....	21
Resistance .....	29
Gender as social practice .....	30
Political and economic changes and rural general practice .....	32
Situating the study .....	35
<i>Feminisation of medical profession</i> .....	35
<i>Gender relations in the home</i> .....	38

<i>Effects of political and economic change on medical work practices .....</i>	<i>40</i>
<i>Resistance to medical hegemony in rural health care .....</i>	<i>44</i>
<i>Rural restructuring and development .....</i>	<i>47</i>
<i>Effects of social change on rural medical service provision .....</i>	<i>49</i>
<i>Rural GPs' responses to structural change .....</i>	<i>54</i>
CHAPTER 2 Recruiting and retaining GPs and their spouses/families in rural locations.....	56
The social practice of rural health care .....	58
Recruitment of rural GPs .....	61
<i>Incentives for Australian trained doctors .....</i>	<i>61</i>
<i>Incentives for overseas trained doctors .....</i>	<i>69</i>
<i>Western Australia.....</i>	<i>71</i>
<i>Maintaining medical care in rural locations .....</i>	<i>72</i>
Retention .....	73
CHAPTER 3 Country general practice: the place and the people .....	78
Landscape .....	82
History.....	91
Rural economy .....	96
Rural restructuring and development.....	98
Providing rural health care.....	101
CHAPTER 4 Methodological matters .....	110
Background.....	111
Gaining Access .....	112
<i>Finding informants.....</i>	<i>113</i>
<i>Ethical considerations .....</i>	<i>115</i>
<i>Pilot project .....</i>	<i>116</i>
Data collection .....	117
<i>Entering/leaving the field.....</i>	<i>121</i>
<i>Participant observation .....</i>	<i>125</i>
<i>Interviews.....</i>	<i>127</i>
<i>Informal discussions .....</i>	<i>130</i>
<i>Archival material .....</i>	<i>131</i>
Data analysis .....	131

<i>Interpretation</i> .....	133
<i>Rigour</i> .....	134
Limitations .....	135
CHAPTER 5 Facing changes to work practices: expectations and experiences of Australian trained male rural GPs.....	136
Feminisation of the medical workforce .....	138
Effects of health reforms on rural GPs' work practices.....	141
<i>The bureaucratic gaze</i> .....	141
<i>Competition</i> .....	145
<i>Indemnity</i> .....	148
Collegial support for rural GPs .....	149
Stress and rural medical culture .....	150
Personal relationships .....	153
'Rural practice is probably general practice at its best' .....	154
The rural GP and the local community .....	156
Future of rural general practice.....	159
CHAPTER 6 Overseas trained doctors and their spouses in country general practice .....	162
Rural medical services and the employment of OTDs .....	163
OTDs and their spouses: life and work in rural Western Australia .....	167
In their own words .....	170
' <i>Push-pull</i> ' factors attracting overseas trained doctors to work in rural Western Australia.....	170
Security .....	171
Incentives .....	172
Cultural adjustment.....	173
Isolation .....	174
Social adjustment.....	176
Professional adjustment to rural general practice .....	177
<i>Bureaucracy</i> .....	179
<i>Indemnity</i> .....	180
<i>Professional relationships</i> .....	181
The future of rural general practice .....	183

CHAPTER 7 ‘Heroes and fairy wrens’: the social practice of female rural GPs .....	186
Background .....	187
The feminisation of the medical workforce .....	189
Balancing work and home .....	193
Gender and rural general practice .....	195
<i>Female GPs’ experience of changes to rural general practice</i> .....	197
<i>Gender relations in the rural medical workplace</i> .....	199
<i>Female rural GPs’ responses to hegemonic practices</i> .....	201
<i>Multiple femininities of rural female GPs</i> .....	204
<i>Multiple masculinities of rural male GPs</i> .....	207
The future of rural general practice .....	209
CHAPTER 8 On being a ‘good’ spouse to a rural GP .....	212
Hegemonic gender relations in marriage .....	215
Reproducing hegemonic gender relations in the face of social changes .....	219
Marriages in a rural setting .....	221
The social practice of being a rural GP’s spouse .....	224
<i>Moving to a rural area</i> .....	225
<i>Conforming to hegemonic gender relations</i> .....	226
<i>The cost of conformity</i> .....	228
<i>Identity</i> .....	229
<i>Multiple femininities</i> .....	232
<i>Downsizing career aspirations</i> .....	235
<i>Resistance to structural constraints</i> .....	236
<i>Male spouses</i> .....	238
<i>Multiple masculinities</i> .....	238
The future of rural general practice .....	240
Conclusion .....	244
References .....	252
Appendix 1a .....	270
Appendix 1b .....	272
Appendix 1c .....	273
Appendix 2a .....	274

Appendix 3.....	276
-----------------	-----

## **LIST OF TABLES**

Table 1 Rural, Remote and Metropolitan Areas classification for communities: population sizes for rural and remote categories	3
Table 2 Modified RRMA classifications for population sizes and GP services in rural centres covered by the GSDGP	3
Table 3 Snapshot of the shires in the GSDGP	85
Table 4 Classification of GPs and spouses	115
Table 5 Total number of GPs working in GSDGP and total number of GPs interviewed	118
Table 6 Demographics of male GP participants	118
Table 7 Marital status of male GPs	119
Table 8 Demographics of female GP participants	119
Table 9 Marital status of female GPs	119
Table 10 Location of OTD participants	120
Table 11 Overseas trained doctors: length of time in rural general practice	120
Table 12 Location of spouses	121
Table 13 Spouses' employment	122

## **LIST OF MAPS**

Map 1 Divisions of General Practice in Australia	64
Map 2 Western Australian Divisions of General Practice	79
Map 3 Localities within the Great Southern Division of General Practice (GSDGP)	80
Map 4 Shires in the Southwest and Great Southern Region of Western Australia	81

## **LIST OF FIGURES**

Figure 1 Diagram of an index tree	132
-----------------------------------	-----

## **ABBREVIATIONS AND ACRONYMS**

ACCC	Australian Competition and Consumer Commission
ACRRM	Australian Centre for Remote and Rural Medicine
ADGP	Australian Divisions of General Practice
ADTOA	Australian Doctors Trained Overseas Association
AFGP	Australian trained female GP
AFSP	Female spouse of an Australian trained doctor
AMA	Australian Medical Association
AMC	Australian Medical Council
AMGP	Australian trained male GP
AMSP	Male spouse of Australian trained doctor
AMWAC	Australian Medical Workforce Advisory Committee
ARC	Australian Research Council
ARRWAG	Australian Rural and Remote Workforce Agency Group
CEO	Chief Executive Officer
CME	Continuing Medical Education
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
ECU	Edith Cowan University
GP	General practitioner
GSDGP	Great Southern Division of General Practice
HIC	Health Insurance Commission
HSM/DON	Health Services Manager/Director of Nursing
NESB	Non-English speaking background
OFGP	Overseas trained female GP
OFSP	Female spouse of an overseas trained doctor
OMSP	Male spouse of a overseas trained doctor
OMGP	Overseas trained male GP
OTD	Overseas trained doctor
PIP	Practice Incentive Program
PRV	Permanent resident visa
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia

RMFN	Rural Medical Family Network
RRP	Rural Retention Program
RWA	Rural Workforce Agencies
TRV	Temporary resident visa
WA	Western Australia
WACRRM	Western Australian Centre for Remote and Rural Medicine

## INTRODUCTION

An Australian Commonwealth Government report titled *Rural, Regional and Remote Health: Indicators of Health* released in May 2005 confirmed findings from the 1998 report *Health in Rural and Remote Australia* that proportionately more Australians living in non-metropolitan areas suffer from serious disease, illness and injury than those living in metropolitan areas. The further the distance from a metropolitan area, the higher are the rates of morbidity and mortality. Both reports also found disease and illness often relate directly to socio-economic factors such as living conditions, social isolation and distance from health services (Phillips, 2005; Strong, Trickett, Titulaer, & Bhatia, 1998).

Health care services in rural Australia are inadequate not least because rural locations do not have the range of services available in metropolitan centres. Difficulties attracting and retaining rural health professionals, and not just doctors, compound the problem (Australian Institute of Health and Welfare, 2002; Strasser, Hays, Kamien, & Carson, 2000; Strong et al., 1998). Nor is this problem confined to Australia. New Zealand, Britain, the United States and Canada have also experienced problems recruiting health professionals to work in rural areas (Easton, 1997; Hays, 1999; McAvoy, 2000-2001; O'Reilly, 1997). Challenges rural health professionals face include the 'tyranny of distance', isolation, limited professional support and a loss of services such as banking and education that have affected 'a significant element of community vitality and prosperity' (Cocklin & Alston, 2003: 2).

Medicine is one of the most pre-eminent and prestigious professions in Western industrialised societies. Medical practitioners are considered expert authorities in matters related to health and disease, a position secured and maintained by support from successive governments (Freidson, 1970; Germov, 2003a). Alternative service models of health care delivery, such as public health initiatives to improve quality of life, have made little leeway into the dominant

position held by general practitioners (GPs) in rural communities (Smith et al., 2004). A medico-centric approach to health has been so successful in influencing community beliefs that Australians view rural health problems primarily as those of doctor shortages and hospital closures with only muted discourse on other ways to provide health care (Palmer & Short, 2000). The Australian Medical Association (AMA) (2001a: 4) sees providing ongoing medical services as essential for rural communities.

## **Rural general practice**

This study centres on the area covered by the Great Southern Division of General Practice (GSDGP) in rural Western Australia.<sup>1</sup> The project resulted from negotiations between the Centre for Social Research at Edith Cowan University (ECU) and the GSDGP. The GSDGP, as the Industry Partner, assisted the Australian Research Council (ARC) to provide funding for ECU to carry out the project. Rural GPs and their spouses are the focus of the investigation. ‘Rural’ is a contested term with various definitions embracing socio-demographic characteristics such as population density, different types of land use and socio-cultural factors reflecting social relationships and values. Such definitions have been criticised for their limited perspectives where arbitrary representations of the notion of rural paint an inaccurate picture of differences in land use or even between rural and non-rural (Black, 2005). For economy of expression, this thesis will use the term ‘rural’ to designate non-metropolitan areas. The diversity between rural locations is also acknowledged and requires further explanation. To differentiate between metropolitan, rural and remote locations, the Department of Primary Industries and Energy and the Department of Human Services and Health published the Rural, Remote and Metropolitan Areas (RRMA) classification for population sizes in 1994. The RRMA system classified remoteness based on 1991 population Census data and Statistical Local Area (SLA) boundaries. It divided geographic areas into three zones: metropolitan, rural and remote and has been used as a proxy for access to health services (see Table 1):

---

<sup>1</sup> The role of the Divisions of General Practice will be explained later in the thesis.

**Table 1: Rural, Remote and Metropolitan Areas classification for communities: population sizes for rural and remote categories**

<b>Rural Remote and Metropolitan Areas (RRMA) classification</b>	<b>Population size</b>
<b>RRMA 3</b> large rural cities	25 000 – 99 999
<b>RRMA 4</b> small rural centres	10 000 – 24 999
<b>RRMA 5</b> other rural centres	< 10 000
<b>RRMA 6</b> remote centres	> 5000
<b>RRMA 7</b> other remote centres	< 5000

Source: (Department of Primary Industries and Energy & Department of Human Services and Health, 1994: 4)

The RRMA classification system is currently under review. The review aims to develop a better system that takes into account geographic data as well as workforce shortages and issues related to the health and wellbeing of a region (Australian Department of Health and Ageing, 2005). However, while the RRMA classification system has been contested and is open to ongoing debate, a modification of it is suitable for use in this thesis. For the purposes of this study, distinctions are made between large, medium and small rural centres according to population size and number of GPs practising in each location in the GSDGP (see Table 2). A non-metropolitan centre with a population of over 20 000 with several general practices serving the community is termed a large rural centre. A town with a population between 4000 and 19 999 serviced by one or more group general practices is classified as a medium rural centre. A small rural centre denotes a population under 4000 where a solo GP provides medical services.

**Table 2: Modified RRMA classifications for population sizes and GP services in rural centres covered by the GSDGP**

<b>Classification</b>	<b>Large rural centre</b>	<b>Medium rural centre</b>	<b>Small rural centre</b>
<b>Population</b>	>20 000	4000-19 999	<4000
<b>General practices</b>	8 group 1 solo	6 group	8 solo

Recruiting and retaining GPs is a high priority on the Commonwealth government's rural health agenda (Australian Government Department of Health and Ageing, 2004). For the last 20 years, research into the provision of medical services in rural areas has found that Australian trained doctors are often reluctant to leave the cities (Boffa, 2002; Kamien, 1987). In an increasingly

uncertain social, political and economic climate in which health professionals now work, the decision to move to rural general practice may seem unattractive for many GPs and their spouses,<sup>2</sup> given their professional or employment aspirations and their children's educational needs. Consequently, some towns and regions are unable to recruit GPs at all while in others GPs and their families are adversely affected by the conditions under which they are expected to live and work (Strasser et al., 2000; Strasser, Kamien, & Hays, 1997).

Various solutions to the problem have been proffered. The *Medicare Plus* package, introduced by the commonwealth government in 2004, includes a commitment to improve medical services by training more doctors in Australia. But this strategy is long-term. For now, Commonwealth, state and local governments are offering generous incentives to assist GPs and their families in the hope of attracting them to rural areas so they will want to stay. Incentives include subsidised relocation grants, accommodation, opportunities for continuing medical education and locum assistance (Australian Rural and Remote Workforce Agencies Group, 2003-2004; Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002). Overseas trained doctors (OTDs) are being employed to address the immediate problem and provide services in locations unable to attract Australian trained doctors (Australian Government Department of Health and Ageing, 2004; Australian Medical Workforce Advisory Committee, 2004b; Donovan, 2003; Roach, 2003).

A report to the Australian Health Ministers' conference from Australian Health Care Agreement Reference Groups in 2002 argued that, despite efforts to improve recruitment and retention, the 'rural health and aged care system continues to fall behind in providing access for local rural communities to comprehensive, appropriate health and aged care services' (Australian Health Care Agreement Reference Groups, 2002: 54). Some researchers argue that the sickest people, including those from low socio-economic groups and Aboriginal communities who need medical care the most, often have great difficulty accessing services. A contributing factor to rural shortages is medical

---

<sup>2</sup> I use the term 'spouse' to include personal partners of GPs who are not married to each other.

practitioners preferring to live and work in areas of higher socio economic status (Boffa, 2002). A report commissioned by the Australian Medical Association in 2001 predicts even greater shortages of rural GPs (Access Economics, 2002); thus a deeper enquiry into the problem is warranted. Evidence suggests that rural general practice is in transition, which is creating an air of uncertainty and frustration amongst rural GPs (Strasser et al., 1997; Wainer, 2002). Factors contributing to that uncertainty and frustration need examination.

Most research on recruitment and retention has centred on the relationship between GPs and the rural environment in which they live and work and has examined issues such as the effects of isolation, the lack of services, and limited professional, occupational and educational opportunities (Strasser et al., 1997; Wainer, 2002). Proffered solutions to such difficulties have included providing locum relief, financial incentives, and better housing and working conditions (Humphreys & Rolley, 1998; Strasser et al., 2000; Strasser et al., 1997). While a rural setting cannot always meet the professional and lifestyle expectations of GPs and their spouses, keeping the solutions centred on the needs of individual GPs and their families, or on the disadvantages of rural 'space', works against critically examining the issue within a broader social context. By opening up the discourse to analyse the relationship between structural factors and social practice, this thesis expands the parameters within which to view the problem and consider innovative solutions. The thesis demonstrates how structural factors impact on the social practice of rural GPs and their spouses. More specifically, it examines how gender relations and political and economic structures affect the actions, expectations and experiences of rural GPs and their spouses. This approach locates recruitment and retention in a broader social context and offers a more nuanced understanding of this complex issue.

There are many definitions of structure in a social context.<sup>3</sup> I draw on Connell's (1987: 92, 107) notion of social structure as the recurring pattern of social relations that is informed by a complex interplay of power evident in relationships within and between social institutions. Power is diffused through

---

<sup>3</sup> I use the terms 'structure' and 'social structure' interchangeably.

these institutions such as the State,<sup>4</sup> the health system and the family and can manifest in ideas about social relations that are reproduced to support dominant groups. At one level, social structure conditions social practice and lies beneath ‘the surface complexity of interactions and institutions’ (Connell, 1987: 93), providing a ‘template’ for how people relate to each other. At another, social structure acts to constrain behaviour or practice that deviates from the norm. In each of these ways, there is a relationship between structure and social practice.

Connell (1987) suggests that social institutions are informed by a range of beliefs and practices that underpin power relations and help explain the possibilities and constraints for social practice and their consequences. This ‘structure’ of power is evident when considering gender relations. Gender as a structuring or organising principle in social relations permeates all institutions including the family, the workplace and the State. Power relations are also present in political and economic structures that act as organising principles guiding social practice. Connell (1987: 62) argues that the ‘structure’ conditions practice. Social practice reflects how people constitute their social relations in light of structural principles or general rules that guide action, expectations and experiences. Thus, the social structure informs the interpretation and practice of masculinity and femininity, reflecting the ‘norm’ of gender relations in specific contexts (Connell, 1987: 120). In other words gender is something that is ‘done’ in social life rather than something that is abstracted from it (Connell, 2002: 55). Political and economic structures ‘guide’ the action, expectations and experiences of the medical and health professions. Structures endure because they are reconstituted daily in social action.

While structures are reproduced in social practice, they can also be contested. Social action or practice can impact on structure and this process suggests that there is ‘an active presence of structure in practice, and an active constitution of structure by practice’ (Connell, 1987: 94). While structures can constrain practices that deviate from the norm, individuals or groups can resist

---

<sup>4</sup> In this thesis, the noun ‘State’ (with a capital ‘S’) refers in a generic way to the institutions of government in Australia. The noun ‘state’ (without a capital letter) refers to a sub-national region such as Western Australia or Victoria.

recurring patterns of social relations that do not serve their interests. This resistance can lead to conflict and generate tension with those who support such patterns. However, from this tension, changes to those patterns can emerge whereby older structures are replaced by newer ones. This process suggests a dialectical relationship between those who support the structure and those who resist it.

Whilst recognising the contested nature of the term ‘dialectic,’ I define a dialectical relationship between structure and social practice as a relationship in which ideas or practices that oppose each other cause tension that can lead to changes either in the structure or in social practice. More specifically, I use the term ‘dialectical relationship’ when referring to relationships between GPs, between GPs and their spouses and between GPs and other groups where the social practice of groups or individuals may oppose dominant or recurring patterns of social relations. This can generate tension between individuals or groups that can also lead to changes to those patterns. A dialectical relationship can also occur when structural elements oppose the social practice of groups not conforming to the norm. This, too, can cause tension that can lead to changes in the social practice of such groups.

Many scholars from Socrates to Hegel and Marx interpreted and used the term dialectic in various ways to convey, among other things, the notion of tension that exists in a debate when opposing forces or ideas meet. Murphy analyses dialectical theories and draws on the Hegelian notion that:

[T]he structure of reality is a structure of oppositions, of elements that contradict each other and limit each other’s possibilities. Out of this clash of antagonistic tendencies, new forms arise that incorporate the opposing elements, albeit in altered form and with their contradictions now resolved (Murphy, 1971: 95).

Murphy explains that the issues or patterns that conflict with each other cause tension. Within that tension, limitations can be reinforced or transcended. Limitations are transcended when forces that oppose each other intersect and allow a process of change to occur. Thus new ideas and ways of being may emerge.

I argue in this thesis that a dialectical relationship can exist between social structure and social practice. This is evident in the context of rural general practice whereby the social practice of at least some rural GPs and their spouses may oppose recurring patterns within the social structure that do not serve their interests. While their resistance may cause conflict and tension, it can also lead to change. I focus particularly on gender relations and political and economic factors as structural influences affecting social practice. My rationale for choosing these factors over others is twofold. First, at the beginning of the project I sought to examine the extent to which political and economic changes affect the autonomy and control of rural GPs over their work practices. Second, after analysing my findings it became clear that these factors were not the only structural element worth investigating. Gender relations emerged as a driving force affecting social practice in the workplace and in the home. This was evident in GPs' and their spouses' expectations and experiences related to the division of labour, work practices, roles within the family and the community, and recruitment and retention. As a result, the issue of gender relations developed into a central theme in the thesis. Structural factors can influence social practice and can lead to changes to practices that deviate from the norm. By the same token, social practice can also impact on the structure so that it changes.

At least potentially, GPs and/or their spouses have the choice and capacity to resist structural limitations that conflict with their own interests. At the level of practice, tension generated as they respond to limitations often reveals the struggle between conflicting forces and ideas that has the potential to create change. A case in point is female GPs who challenge the work practices of male GPs by demanding more flexible hours. Such a challenge conflicts with conventional notions of medical work practice that have often supported a male model of work patterns espousing long working hours (Pringle, 1998). This model is particularly evident in rural general practice. Female medical practitioners, many of whom are the main caregivers in the home, are generally calling for changes to the long hours they work that make it difficult to achieve a balance between work and home life (Pringle, 1998; Wainer, 2000; Witz, 1992). While their calls for change undoubtedly cause tension amongst their colleagues, they also sow the seeds for change where limitations embedded in conventional

work practices can be transcended to allow new ideas and practices to emerge, an issue discussed later.

The thesis examines the effect of specific structural issues on the social practice of rural GPs and their spouses and on their decision to remain in rural general practice. It draws on theoretical ideas and ethnographic data to provide the framework. The thesis presents its ethnographic findings using discrete chapters to identify responses from different groups of participants to specific themes that are repeated in each chapter. A case in point is the increasing feminisation of the medical workforce and its effects on participants' expectations and experiences of rural general practice. Such a framework allows themes emerging from the data to be examined for similarities and differences within and between groups. This approach permits a more nuanced analysis of factors affecting participants' decisions as to whether they remain in a rural area. It reveals the role social structure plays in influencing the interests of discrete groups that either reproduce or contest enduring patterns of social relations. In this way layers of meaning and understanding emerge that reflect both the complexity of the issue of recruitment and retention and the dialectical relationship between structure and practice. As groups struggle to assert their respective interests in the face of the so-called norm, conflict may occur. However, tension generated within such conflict has the potential to lead to change.

Some studies on recruitment and retention have overlooked the influence structural factors have on social practice and their part in changing the face of rural general practice. The role of gender is important when considering rural GPs' and their spouses' expectations and experiences at a professional and personal level. Historically, rural general practice was often seen more as a vocation and less as a job as GPs heroically worked long hours to meet their patients' demands (see also Fowlkes, 1980; Strasser et al., 1997). Tension created by more women entering the medical workforce who contested conventional models of work practice in favour of flexible working hours is leading to change. Recent British research indicates that some male GPs are also opting for more flexible work patterns (Young, Leese, & Sibbald, 2001). However, limited studies are available on the expectations and experiences of

spouses of rural GPs in the face of structural changes, a theme explored in this thesis.

## **The social practice of gender**

### ***Female rural GPs***

Since the 1980s, the number of women entering the medical profession in Australia has been increasing (Australian Institute of Health and Welfare, 1999a). In the late 1990s, for the first time, over 50 per cent of the medical student intake were women (Australian Institute of Health and Welfare, 1999a). Predictions that women entering medical school will increase from 53 per cent in 1999 to 60 per cent in 2010 support this trend with estimates suggesting that, proportionally, women entering the GP training program could increase from 58 per cent in 1998 to 65 per cent in 2010 (Australian Medical Workforce Advisory Committee, 2000). While studies show that female medical practitioners are more likely to work in metropolitan centres than rural locations (White & Fergusson, 2001), women currently make up over 50 per cent of young doctors training for rural general practice (Wainer, Bryant, & Strasser, 2001) and over 60 per cent of the rural registrar intakes (Wainer, Strasser, & Bryant, 2005).

Compared to their male colleagues, female GPs have generally embraced a different work ethic. Many resist long working hours and prefer to work part-time and spend longer time with patients (Pringle, 1998; Wainer et al., 2001). This suggests a dialectical relationship whereby their ideas and practices conflict with a male model of rural general practice, opening the possibility for change. Part of the reason women medical practitioners prefer working fewer hours is that they shoulder most of the responsibility for childcare and home-making (Lippert & Tolhurst, 2001; Wainer, 2004). Their wishes to better balance the demands of work and home are impacting on medical work practices, often causing conflict and tension but are also paving the way for change (Beagan, 2001; Pringle, 1998; Wainer, 2003).

Structural constraints are illustrated in the dilemma for many female medical practitioners who want to fulfil their role as main caregiver in the home, while at the same time meet the demands of their role in the workplace. Recent research in Australia suggests that, while interest in men's involvement in

childcare may be increasing, at least in theory, as popular support for the traditional sexual division of labour is on the wane, this shift is not reflected in practice. Instead, conventional models of gender roles persist where men's priority is to be the breadwinner and women are cast as the main caregivers (Bittman, Hoffman, & Thompson, 2004). In 1997 older males made up the majority of the rural general practice workforce (Strasser et al., 1997), and recent figures show that the ageing trend is continuing where the average age of the overall medical workforce in 2002 was 46.6 years compared to 44.9 years in 1996 (Australian Medical Workforce Advisory Committee, 2004a). In 1996, 21.8 per cent of medical practitioners were over 55 years compared to 23.7 per cent in 2002. Numbers of female medical practitioners have risen from 27.2 per cent in 1995 to 31.6 per cent in 2002 (Australian Medical Workforce Advisory Committee, 2004a). Trends in current medical workforce participation suggest that by 2010, women will comprise 41 per cent of the GP workforce (Australian Medical Workforce Advisory Committee, 2000). In 2001, 44.3 per cent of medical practitioners worked more than 50 hours per week (Australian Medical Workforce Advisory Committee, 2004a). A higher proportion of rural GPs worked over 50 hours a week compared to their metropolitan colleagues (Australian Government Department of Health and Ageing, 2004: 122). Working long hours is not sustainable for female GPs who are the main caregiver in the family. Findings from the *National Rural General Practice Study* (NRGPS) cautioned against maintaining current models of work practice when developing programs and policy because the rural medical workforce is changing (Strasser et al., 1997). This factor must be considered seriously when planning future rural health services.

### ***Rural GPs' spouses***

GPs seldom live alone while working in rural locations. Kamien (1987: iv) argues that spouses often play a significant role in determining whether the GP stays or leaves a rural community, claiming that the 'success and retention of a doctor depends to a large extent on the adaptability of the spouse'. Yet most studies on recruitment and retention have focused mainly on GPs' needs with far fewer addressing those of their spouses. This study identifies and analyses the needs of both rural GPs and their spouses.

Australian researchers have argued that barriers to recruiting and retaining rural GPs include the lack of employment, education and training opportunities for GPs' spouses (Nichols, 1997; Wise, Nichols, Chater, & Craig, 1996). This perspective is, however, only part of the story. Gender roles in rural medical marriages/partnerships also need examining when considering GPs' spouses' needs. Studies on the recruitment and retention of rural GPs often adopt an uncritical approach to the significance of gender in rural medical marriages/partnerships. An implicit assumption prevails that the division of labour in the home falls within conventional parameters with male as provider and female as the primary caregiver. Many female spouses of rural GPs adopt the role of caregiver and, if they are in paid employment, often work in their spouse's general practice. Male spouses of rural GPs, on the other hand, seldom work within the practice and are more likely to be employed in their original profession (Wise et al., 1996). Male and female spouses' different expectations and experiences are explored later in the thesis. They are set against a backdrop of the dialectical relationship between structure and social practice that is played out in some rural medical marriages/partnerships.

Examining issues related to recruitment and retention from a broader, structural perspective allows a deeper analysis of the frustration many rural GPs experience in the face of social changes. Political and economic changes are not only impacting on their work practices but also on the restructuring and development of rural communities in which GPs and their families live and work.

## **The effects of political and economic change**

### ***Rural centres***

Political and economic changes in the last 20 years have significantly affected those living in rural locations. The positive and negative effects of economic reform are juxtaposed with increasing morbidity and mortality rates for those living in rural areas (Phillips, 2005). Since the mid-1980s the Australian Labor and Coalition governments have shifted policy direction by embracing neoliberalist principles. There has also been a distinct move away from support for the welfare state, with its focus on social protection, towards an increasing

emphasis on competition and cost containment in social policy, such that market forces tend to drive resource allocation (Palmer & Short, 2000; Rodger, 2000; Twaddle, 1996). Economic reform has resulted in less State assistance to rural and farm sectors. Increased use of technology and mechanisation in agriculture has led to out-migration as less labour is required (Haslam McKenzie, 2000). Added to this, essential services such as banking have been withdrawn in many small towns (Tonts, 2000) and those living in rural locations are incurring higher costs to access face to face financial services (Argent & Rolley, 2000). The effects are most keenly felt in the least densely populated areas (Tonts, 2000). Indigenous communities are hardest hit with 16 per cent of Indigenous people living more than 80 kilometres from a bank, and 15 per cent living more than 80 kilometres from a hospital compared to one per cent of non-Indigenous people (Haberkorn and Bamford cited in Larson, 2002: 7). It is within an overall context of rural decline that GPs are being recruited to work in rural locations. The next section indicates that political and economic changes have also affected the health industry including rural medical services.

### ***Rural health services***

Governments in Australia consider the pursuit of economic efficiency and growth as a more secure route to social wellbeing than is political regulation or intervention (Black et al., 2000). Given that an emphasis on competition and cost efficiency has led to reduced access to services in some rural locations it is hard to fathom how the health of rural communities has benefited from these reforms. Rodger (2000) asks how can the most vulnerable be protected from the vagaries of the global economy that prioritises economic rather than social needs? Indeed, a substantial body of evidence points to poorer morbidity and mortality rates among those living in rural locations compared to their urban counterparts, a differential reinforced by current social welfare policies (National Rural Health Policy Forum & National Rural Health Alliance, 1999-2003; Phillips, 2005). These findings point to the need to reassess what constitutes 'equitable' health care and how best to meet that demand.

The medical profession has long dominated the health division of labour 'economically, politically, socially and intellectually' (Willis, 1989: 2).

Currently, doctors continue to exercise authority over other health occupations and shape society's beliefs about health problems and how they should be managed, all of which have important implications for health policy (Germov, 2003a). Yet the position of power held by the medical profession in health care is under scrutiny and is less assured in light of structural changes. While the market place has been deregulated, many doctors complain that the government is increasingly regulating their work (Strasser et al., 1997); thus, they are held increasingly accountable for their actions. Rapid technological change has also made them vulnerable to government surveillance of their work patterns (White, 2000a). Such changes are to some extent undermining their historic autonomy and control of clinical practice, creating insecurity and frustration.

Other structural factors have also created uncertainty in the rural medical workforce. Historically, the Australian system of health care has been based on a philosophy of health care being associated with medical care (Humphreys, 1998; Palmer & Short, 2000; Willis, 1989). Indeed, rural people prefer to access a GP as the first point of contact for any health problem (Strong et al., 1998). Yet when attempts to recruit and retain rural GPs fail, nurses often fill the gap as primary health care practitioners (Duckett, 2004; Pearson, 1993). In the prevailing political and economic climate, health services have undergone significant and rapid changes with various occupations contracting or extending the boundaries of their roles. This has led to health professions often competing to provide services once offered only by the medical profession (Pearson, 1993). Such changes are undermining the authority and control of the medical profession in some contexts, and have caused tension amongst medical practitioners (Strasser et al., 1997; Wainer, 2002). Health policies in Australia have generally maintained a medico-centric focus designed to induce more doctors to practise in rural areas, giving relatively little attention to possible alternative approaches to rural health service delivery (Palmer & Short, 2000). Such a response makes it difficult to implement innovative solutions outside that medico-centric paradigm. Approaching the issue from the broader context of health improvement, the diversity in health care needs among rural communities can be examined, and innovative solutions considered, rather than providing a 'one-size-fits-all' response (Keleher, 1999).

## **Purpose of the study**

This research provides a broader, sociological lens through which to view factors affecting the recruitment and retention of the rural GP workforce. Previous studies have focused on the needs of GPs, identified the disadvantages of rural general practice and examined the relationship between rural GPs and their immediate environment. This project locates GPs' *and* their spouses' expectations and experiences in the context of structural change to understand more deeply the complexity of factors that affect the supply of rural GPs.

Using ethnographic methods, the study examines the effects of structural changes, specifically gender relations and the political and economic climate, on the expectations and experiences of rural GPs and their spouses living and working in the area covered by the Great Southern Division of General Practice in rural Western Australia. It seeks to understand how such changes influence social organisation and are experienced at the level of practice. The study also considers GPs and their spouses/partners as a 'unit' when discussing issues related to recruitment and retention. Given that many rural centres are drawing heavily on overseas trained doctors (OTDs) to maintain the rural general practice workforce, factors underpinning their choices to work in rural Australia, and their decision to stay or leave, are also considered. OTDs and their spouses, many of whom come from culturally and linguistically diverse backgrounds, inevitably bring with them aspirations that may not adequately be fulfilled in a rural Australian location. Rarely has research focused on this group's experiences and expectations of rural general practice and country living. This study fills that gap.

The project will contribute to a growing body of research forging fruitful dialogue between social scientists, medical practitioners, government, and industry or community groups. Findings from this study will be made available to national and local agencies such as Divisions of General Practice and University Departments of Rural Medicine. The findings will also assist the Industry Partner involved in the project, the GSDGP, to improve its services and support structures for the GPs it employs. The Industry Partner may also use the results to contribute to debate about strategies to attract and retain general

practitioners to work in rural locations and thus to improve the quality of rural health and medical services.

### **Areas of enquiry**

The dialectical relationship between structure and social practice underpins this enquiry to allow a broader, sociological analysis of the expectations and experiences of rural GPs and their spouses to emerge. Questions generating the enquiry are:

- What factors contribute to the decision made by GPs and their spouses to live and work in a rural location?
- To what extent do the conditions under which GPs and their spouses live and work influence their decision to stay in or leave rural general practice?
- Might difficulties in attracting and retaining GPs and their spouses lead us to consider other ways to provide health services to those living in rural locations?

### **Chapter overview**

The first four chapters of the study provide a backdrop within which to locate the findings from this ethnographic research. Chapter One introduces the social context of the project by examining changes in Western industrialised countries that have impacted on the dominant role of the medical profession and the delivery of rural medical services in the last 30 years. It focuses on concepts of power to examine how enduring patterns of social relations are either reproduced or contested. The role played by political and economic factors and gender relations in a rural general practice setting is significant. It demonstrates the importance of structural influences on the expectations and experiences of rural GPs and their spouses, a theme given limited consideration in other research on recruitment and retention. The ideas of Antonio Gramsci and Pierre Bourdieu help to explain notions of power embedded in structural factors that affect social practice whilst also revealing the concept of resistance when dominant ideas are contested. Research by Robert Connell, Rosemary Pringle and Ken Dempsey extends these explanations to include gender relations

generally, and in a medical context and a rural setting more specifically. The work of critical medical anthropologists and sociologists, including Hans Baer, Merrill Singer and Kevin White helps to locate the effect on medical practitioners of wider social changes that impact on their autonomy and control in a work setting.

Chapter Two presents a more specific explication of research on recruiting GPs to work in rural locations and on retaining their services. It provides a background to some of the policies related to the delivery of rural health services that indicate their medico-centric focus. These include an increasing emphasis on attracting OTDs to work in rural areas of need where GP positions are not filled by Australian trained medical practitioners. Chapter Three takes the reader on a journey through the area covered by the Great Southern Division of General Practice in rural Western Australia that is the focus of this research. The aim is to convey not only the sense of isolation and distance between the rural towns in which GPs and their spouses live but also their diversity that questions the notion of 'rural' as a homogeneous concept. The diversity is reflected in the historical, social and economic developments that impact on health service delivery and issues related to recruitment and retention of GPs. Chapter Four sets out the methods used to gather information, access participants, organise and conduct interviews, manage and store information and analyse the findings.

The final four chapters submit the findings of the research. Each starts with information specific to the focus of the chapter that locates it in a wider social context. The main content of each chapter presents findings based on interviews with GPs and their spouses. Participants' own words are used to illustrate the themes emerging from their responses and to reveal the dialectical relationship between structural elements and social practice in the medical workplace and the home. Chapter Five examines the expectations and experiences of Australian trained male GPs living and working in rural locations. Political and economic changes and the increasing feminisation of the medical workforce are affecting GPs' autonomy and control of their work practices and are changing the face of rural general practice. Despite this, most GPs enjoy working in a rural area and plan to stay. Chapter Six focuses on the lives of

overseas trained doctors working in rural locations, specifically addressing some of the cross-cultural challenges they face and how these affect enjoyment of their work and living conditions. Chapter Seven considers how dominant ideas about gender relations affect social practice and focuses on female rural GPs, many of whom balance the demands of work and home. It also examines how female rural GPs' expectations and experiences of their work practices intersect with, and affect, those of their male colleagues. The final chapter explores the challenges faced by spouses of rural GPs and the different expectations and experiences of male and female spouses in light of hegemonic beliefs regarding gender relations.

The conclusion draws together reasons why this study is important. It notes that, while research into attracting and retaining GPs in rural areas is not new, the focus has often centred on the expectations and experiences of the GP. While this study acknowledges commonalities in findings with previous research, it broadens the parameters in which to view the problem by probing more deeply into factors influencing the provision of rural GP services. It also foregrounds the role of rural GPs' spouses and seeks to understand how their expectations and experiences influence decisions to stay or leave rural general practice. The study's findings show that critically examining the relationship between broader structural issues and social practice offers a more nuanced appreciation of the range of factors that affect the lives and work practices of GPs and their spouses in rural locations. This in turn has implications not only for the recruitment and retention of rural GPs but also for other aspects of the delivery of health care in rural areas.

## **CHAPTER 1**

### **The changing face of rural general practice: the relationship between structure and social practice**

Dramatic social changes in the last 40 years have affected rural general practice. Growing numbers of women are entering the medical profession (Pringle, 1998; Wainer, Bryant, Strasser, Carson, & Stringer, 1999), government regulation in the area of medical practice is increasing (Carson & Stringer, 1998), non-medical health professionals are competing to provide services historically offered only by the medical profession, and patients as health ‘consumers’ are calling for more accountability from medical practitioners for their actions (Germov, 2003a). The questions raised in the context of rural general practice are the extent to which such changes have affected rural GPs’ work patterns and have influenced choices they and their spouses make to remain in a rural area.

To answer these questions I locate the lives and work practices of rural GPs and their spouses in the context of wider social relations to seek to understand factors influencing their responses. More specifically, I examine the dialectical relationship between structure and social practice in different contexts. Changes to work practices are occurring as increasing numbers of women enter the workforce and government policy shifts direction away from social welfare towards an economic emphasis on competition and cost effectiveness. I focus particularly on gender relations and political and economic factors as major structural principles impacting on the actions, expectations and experiences of rural GPs and their spouses.<sup>5</sup>

Ortner’s (1989: 13) research found that ‘practice is inextricably tied to the notion of structure’. The dynamic nature of this relationship is revealed when changes to social structure affect social practice, and changes in social practice have the potential to alter the recurring patterns of social relations rather than just

---

<sup>5</sup> Giddens (1986: 185) uses the term ‘structural principles’ to denote principles that underlie social organisation.

reproduce them. A case in point is an heroic work ethic influencing work patterns in rural general practice. Historically, rural doctors' long working hours have allowed little time at home. Many female medical practitioners are choosing to work fewer hours, often to balance the demands of work and home (Pringle, 1998; Wainer, 2004). Their interests conflict with the 'norm' in calling for structural changes in the medical workplace. Rather than reproduce the conventional work ethic, female medical practitioners are resisting it. While not all female GPs support this move, nor male GPs resist it, a dialectical relationship is revealed when calls for structural changes lead to a struggle between those supporting conventional ideas of work practices and those contesting them. Tension generated from this struggle has, in some instances, successfully led to change. Some male medical practitioners are now also opting to work fewer hours (Pringle, 1998; Young et al., 2001).

To examine the dialectical relationship between structure and social practice I initially draw on particular themes in the works of Gramsci (1999) to provide a theoretical framework to understand factors affecting the expectations and experiences of rural GPs and their spouses. I also identify specific ideas in Bourdieu's (1989; 2004; 1977; 2002) extensive body of work that offer a more nuanced perspective to appreciate how enduring patterns of social relations are reproduced or are contested and sometimes changed. The chapter then addresses the notion of a dialectical relationship more specifically. First, it examines Connell's (1987; 2002) work on gender relations and the research of Pringle (1998) and others to focus particularly on gender relations in a medical setting. Dempsey's (1990; 1992) work offers a more specific explanation of gender relations in a rural setting. Second, it draws on the work of critical medical anthropologists Baer (1986), Singer (1990; Singer & Baer, 1995) and others to examine the effects of political and economic changes on rural general practice. The chapter explores these themes further in light of previous research on social changes by reviewing literature on gender relations in the workplace and the home and the effects of political and economic change on medical practice, rural restructuring and development, and the provision of rural medical services. The chapter starts by providing a theoretical backdrop in which to locate the

relationship between structure and social practice by examining the idea of power in recurring patterns of social relations. It begins with the notion of hegemony.

## **Hegemony**

The basic premise of Gramsci's theory of hegemony is that we are not ruled by force alone but also by ideas (Bates, 2002: 247). Hegemony is a relationship of power where one social group or class, through their position of leadership and cultural dominance, exercises power over subordinate groups in various ways (Forgacs, 1988: 306-307). According to Gramsci, the State, made up of public institutions such as the government, the judiciary and the police, embodies the ideas of the dominant social group or ruling class; these institutions are used to legally enforce those ideas on civil society, regardless of the wishes of those who make up civil society (Bates, 2002: 247; Forgacs, 1988: 306-307; Gramsci, 1999: 12). Gramsci describes civil society as 'private' institutions such as the family, trade unions and the church. In his opinion, dominant groups in civil society use these institutions in order to promote their ideas and gain the consent of subordinate groups. Thus, a consensual reality is formed when subordinate groups agree with the ideas, values and beliefs put forward by a dominant group to the extent that such ideas are accepted as the norm or common sense. In this way dominant groups, aided by social institutions reinforcing their ideas, are able to direct social and political consciousness (Bates, 2002: 247; Gramsci, 1999: 12). Gramsci (1999: 12) argues that subordinate groups 'spontaneous[ly] consent' to the norms of social life espoused by dominant groups. This occurs because a dominant group holds power and leadership positions within the social order:

...the entire complex of practical and theoretical activities with which the ruling class not only justifies and maintains its dominance, but manages to maintain the active consent of those over whom it rules (Gramsci, 1999: 244).

However, a dominant group needs to win support for its ideas to strengthen its power base. Developing alliances is central to the 'organisation of consent' (Simon, 1982: 21). The dominant group forms alliances with other groups by considering their interests and combining them with its own thereby

strengthening its position (Gramsci, 1999: 60; Simon, 1982: 23). One result of this process is that subordinate groups see the ideas of a dominant group supporting the common good in a way that reflects ‘a deeply held belief that the superior position of the ruling group is legitimate’ and that ‘the hegemonic group stands for a proper social order in which all men [*sic*] are justly looked after’ (Femia, 2002: 266). People are more likely to agree to the dominant group’s ideas if they fit their notion of ‘common sense’ or conventional wisdom regarding social practice. Thus, hegemony is a relation ‘not of domination by means of force, but of consent by means of political and ideological leadership. It is the organisation of consent’ (Simon, 1982: 21).

Gramsci (1999: 196-197; Simon, 1982) also maintains that people’s notion of common sense, or the way they perceive the world in which they live, is generally unreflective and uncritical. Each individual tends to see the social order as a given, rather than something that has been socially constructed. Williams (1994: 596) explains that subordinate classes are conscious only of the ideology of the dominant class because, axiomatically, the dominant class defines and controls the production of ideas. In other words, ideas serving the dominant group’s interests are reproduced when subordinate groups accept such ideas as the norm.

Gramsci describes hegemony as more than just an ideology in that it exists also in practice. It goes beyond ideas and beliefs to encompass a ‘whole social process’ that interlocks ‘political, social and cultural forces’ that impact on social practice (Williams, 1994: 595). According to Williams, the hegemonic process involves the relationship between ideas and their implementation as practice. It entails:

... a whole body of practices and expectations over the whole of living, our senses and assignments of energy, our shaping perceptions of ourselves and our world. It is a lived system of meanings and values - constitutive and constituting - which, as they are experienced as practices, appear as reciprocally confirming (Williams, 1994: 596).

Gramsci developed his work from within a Marxist framework as a form of class analysis within a distinct historical period. I take some of his insights and

situate them in a contemporary setting. I use the concept of hegemony to indicate the relationship between dominant groups such as the male rural GPs and subordinate groups such as female rural GPs and female spouses of rural GPs. This relationship is influenced by structural principles, or the general rules that guide action, played out in social practice. However, ideas supporting the dominant group's interests that are accepted as the norm by subordinate groups can also be contested. Such resistance implicitly questions the notion of whose interests the so-called 'common good' is effectively serving. Thus, counter-hegemony may also be evident at the level of social practice. Subordinate groups may form alliances to resist, and sometimes usurp the position and ideas of the dominant group (Gramsci, 1999: 77-78). This process illustrates a dialectical relationship whereby subordinate groups who want to pursue their respective interests may, in the process, contest recurring patterns of social relations and cause tension in the relationship with the dominant group. In other words, social practice may resist structural elements and create the potential for change to such structures in some contexts.

In a contemporary medical context the majority of rural GPs have, for many years, been male. They have held a dominant role, supported by the State, in the delivery of health services. Their work practices have involved long hours (Australian Government Department of Health and Ageing, 2005: 105, 121-122). Most male GPs are married and their spouses have adopted the primary caregiving role in the social organisation of the family and have supported the work of their GP partners (Nichols, 1997; Wise et al., 1996). Female medical practitioners have also sustained the dominant group's interests by fitting in with its ideas regarding work practices despite many female medical practitioners also being the main caregivers in their families (Bryant, 1997; Crompton & Le Feuvre, 2003; Lapeyre, 2003). However, as their numbers grow in the medical workforce, many women are contesting inflexible work patterns as not serving their interests. They are seeking, instead, work practices that offer a balance between work and home (Wainer, 2004). Some male GPs also support the notion of changing hegemonic ideas about work patterns and applying them to practice (Wainer et al., 2001; Young et al., 2001). They support their female colleagues in this context which reflects Gramsci's (Gramsci, 1999) notion that alliances

between groups can build their strength in order to challenge so-called conventional wisdom. Such a process suggests that resistance to the social structure has the potential to transform dominant ideas about medical work and impact on practice.

In his extensive body of work, Bourdieu (2002: 19) discusses the notion of the individual as an agent for potential change rather than as a passive recipient of the ideas espoused by dominant groups. Somewhat similarly, in his structuration theory, Giddens (1986: 16) discusses the ‘dialectic of control’ where structures of domination in social systems do not automatically produce ‘docile bodies’. In other words, dominant structures or institutions can also be influenced by the activities of subordinated people who cease being passive individuals and become agents for change. Bourdieu (2002: 19) argues that agents think reflexively. When they become conscious and critical of the objective, structural reality, they are less likely to be motivated to internalise, or accept as the norm, those objective realities that do not serve their interests. Bourdieu sees the two, structure and agent, in a dialectical relationship:

... the objective structures ... setting aside the subjective representations of agents, form the basis for these representations and constitute the structural constraints that bear upon interactions; but, on the other hand, these representations must also be taken into consideration particularly if one wants to account for the daily struggles, individual and collective, which purport to transform or to preserve these structures (Bourdieu, 1989: 15).

Nonetheless, a hegemonic relationship implies that dominant groups may use their power to gain acceptance for their ideas from those in subordinate groups. More specifically, male rural GPs who work long hours may exert their authority to gain consensus for their work practices by subordinating those of female GPs who want to work fewer hours. The power and status accorded male GPs in their role as rural doctors and their position as providers for their families may also influence their spouses to subjugate their own professional or educational aspirations and assume the role of primary caregiver in the home. However, female spouses can also act as agents for change and resist structural constraints in the context of work practices by expressing and acting on their

own sense of entitlement to seek occupational fulfilment. Acting as agents, they have the potential to transform rather than reproduce hegemonic ideas and practices. In other words, they can support their own interests and contest hegemonic ideas, values and discourses.

Gender as a structuring principle in Western industrialised societies generally locates men as dominant and women as subordinate in social relations (Connell, 1987, 2002). Bourdieu (2002) suggests that men's dominance is taken for granted and many women accept their own subordination without realising that such patterns of gender relations are not natural but are socially constructed and reproduced to make the dominance of men in gender relations seem natural. Bourdieu (1977; 2002) introduces the notion of symbolic violence which plays an important role in his analysis of domination in general and is central to understanding how inequitable gender relations are reproduced. In this context, symbolic violence occurs when the dominance of men is legitimated as part of the normal social order whereby women are treated as inferior and denied resources (Bourdieu & Wacquant, 2002: 167). Jenkins (1993) sees Bourdieu's idea of symbolic violence as contributing to a theory of socialisation whereby various ways of thinking and acting are internalised by groups and classes in a way that masks underlying power relations. Kraus describes symbolic violence as:

... a subtle, euphemised, invisible mode of domination that prevents domination from being recognised as such and, therefore, as misrecognised domination, is socially recognised (Kraus, 1993: 172).

Connelly and Healey explain further by stating that symbolic violence:

... represents the way in which people play a role in their own subordination through the gradual internalisation and acceptance of those ideas that tend to subordinate them. It is an act of *violence* precisely because it leads to the constraint and subordination of individuals, but it is also *symbolic* in the sense that this is achieved indirectly and without overt and explicit acts of force or coercion (Connelly & Healey, 2004: 15, emphasis in original).

Internalising 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 2002: 167) implies that such actions

are perceived as a normal part of gender relations. According to Bourdieu, women's complicity occurs because they accept uncritically ideas constructed by the dominant group as the way things are and ought to be:

Of all the forms of 'hidden persuasion' the most implacable is the one exerted, quite simply, by the *order of things*' (Bourdieu & Wacquant, 2002: 168).

Bourdieu (2002: 73) introduced the notion of 'doxa', describing it as 'an uncontested acceptance of the daily lifeworld'. He uses the term to illustrate how dominated social groups, such as women, accept their subordination without realising they are being oppressed and without seeking to change the situation by challenging the so-called conventional wisdom (Webb, Schirato, & Danaher, 2002). In other words, Bourdieu suggests that women's 'doxic acceptance' of their subordination does not occur because they feel coerced or manipulated. It occurs because they accept as axiomatic men's dominance even though they may be treated unfairly and restricted in their expectations or opportunities (Webb et al., 2002: 25). Bourdieu argues that many women accept men's dominance *because* they misrecognise the symbolic violence being perpetrated and instead experience it as something normal and natural within the existing social order. In doing so, they legitimate such dominance and prevailing gender practices are reproduced. According to Bourdieu:

... symbolic violence accomplishes itself through an act of cognition and of misrecognition that lies beyond - or beneath - the controls of consciousness and will' (Bourdieu & Wacquant, 2002: 172)

Bourdieu argues that symbolic violence typically involves 'misrecognition' whereby relations of power are often hidden and seen 'not for what they objectively are but in the form which renders them legitimate in the eyes of the beholder' (Bourdieu & Passeron, 1977: xiii). Actions that subordinate the needs of women constitute 'symbolic violence' when they hide power relations at a structural level that restrict women's choices at the level of social practice. Evidence of this is found in contexts where women accept less wages than men for doing the same amount of work, where women are employed full-time and also take primary responsibility for the demands of domestic duties and

childcare, or where women are restricted in furthering their occupational or educational aspirations. According to Kraus (1993) 'complicity' implies that if someone is confronted with an act of symbolic violence such as being treated as inferior, they may decode relevant signals and sense the violence at some level but not recognise it for what it is, a form of domination. While some women may be aware of acts of symbolic violence directed against them, they are often constrained to change the situation by the very structures that reproduce the 'order of things'. Other women may take for granted men's dominance in gender relations believing it to be normal behaviour or even that it supports the common good. Some women may not want to change prevailing gender relations because of the benefits they gain by conforming to conventional expectations. In effect, women may 'misrecognise', or choose to ignore, or feel powerless to change the power imbalance embedded in such relations that, while hidden, is inequitable and can be exploitative.

While Bourdieu's view of gender relations has been criticised as being overly deterministic (Butler, 1990, 1993; Jenkins, 1993), it nevertheless highlights the inequitable distribution of power. However, Bourdieu claims that the dominant group is not consciously duplicitous in reproducing inequitable gender relations (Lechte, 1996). Wacquant (Bourdieu & Wacquant, 2002: 168) suggests that Bourdieu's theory of symbolic violence differs from Gramsci's theory of hegemony in that dominant groups do not consciously seek to gain the consent of subordinate groups:

... the legitimation of the social world is not ... the product of a deliberate and purposive action of propaganda, or symbolic imposition; it results, rather, from the fact that agents apply to the objective structures of the social world structures of perception and appreciation which are issued out of these very structures and which tend to picture the world as evident (Bourdieu, 1989: 21).

Rather, the privileged position of the dominant group within the social order and within social institutions gives it a platform on which to gain the consent of subordinate groups into believing the conventional wisdom it has effectively constructed (Lechte, 1996). That this 'conventional wisdom' is accepted is evident in the beliefs and practices of both the dominant and dominated classes

or groups (Bourdieu & Wacquant, 2002). Ideas supporting the dominant position of men in gender relations have been legitimated as part of the social order and underpin the formation of a consensual reality. This suggests that actively seeking women's consent to such ideas is no longer necessary as many have accepted and internalised such ideas and practices as normal and natural.

While the notion of symbolic violence may help in understanding how inequitable power relations between groups are reproduced, it fails to explain women's complicity adequately. A more nuanced interpretation puts forward the idea of the consequences for women if they do not comply with dominant expectations. Indeed, some women may accept that gender relations are inequitable but choose not to contest the 'daily lifeworld' for various reasons. They may choose to comply because of social pressure or because they feel powerless to change the situation or may not want to change the situation because of what they may stand to lose if they challenge the existing social order. They may also comply because of the enormous effort it would take to go against their social conditioning and challenge male dominance and privilege and because of the structural constraints they may encounter if they did challenge the social order. Women may not only accept their subordinate role to fit the so-called 'norm'; they may also choose that role because they are more likely to be valued and gain social acceptance if they conform to hegemonic practices where men are the main provider and women are the primary caregiver, even if women are in paid employment. Thus, men's position of dominance occurs because ideas supporting their position of power in the social order are also seen as normal and natural. Women who are married or in a committed relationship may also acquire social status, material wealth and financial security if they partner with someone from within the hegemonic group such as a doctor or a lawyer. Rhodes's (2001: 353) qualitative analysis of wives of professionals in the mining industry shows how a 'good wife' is one who subjugates her professional interests to become a 'consort, helpmate and moral supporter' where she can 'release her engineer from domestic duties, to free him from childcare and to withdraw her own occupational competition in order to promote instead his image through her social skills'. This choice assures her 'financial security and a comfortable lifestyle'.

If women demand changes to structural inequities present in current gender relations that reinforce their subordinate status in their relationship, they may risk losing the benefits of their position if the partnership or marriage ends (Tavris, 1992). This suggests that women's complicity to conform may also be shaped by their perceptions of the consequences if they resist. Indeed, the costs are more pervasive because of what women stand to lose socially and economically if they challenge the prevailing social order. According to West and Zimmerman (1987: 146) women are held to account when they resist hegemonic expectations by 'fail[ing] to do gender properly' rather than the structuring principles that underlie the inequitable distribution of power and reproduce the dominance of men in gender relations.

## **Resistance**

Connell (1977) argues that, when analysing hegemony, counter-hegemonic activity needs consideration. He claims that the relationship between dominance and subordination is never total. In other words, no group exercises total control over another group. Instead there are always 'circles of resistance' (p.207). Connell suggests that cultural forces of control within the hegemonic relationship can be contested, weakened and changed as part of a counter-hegemonic process (p.220). Ortner (1989: 200) argues that tension generated from the struggle in resisting dominant ideas and beliefs at the level of social practice paves the way for structural change. Yet she also suggests that if people do not see alternatives to prevailing hegemonic ideas and practices, or do not have the institutional power to implement the alternatives, dominant practices are reproduced. In a gendered context, power can be contested when male dominance is resisted. Ortner (1989: 196) suggests that the concept of power is present in hegemonic structures and 'practised ... lived ... enacted ... challenged, defended, renewed, changed'. Indeed, according to Williams, the practice of hegemony does not passively exist as a form of dominance but is constantly:

...renewed, recreated, defended and modified. It is also continually resisted, limited, altered, challenged by pressures not at all its own (Williams, 1994: 598).

Rural general practice is a site where change is occurring as hegemonic ideas about medical work practices are resisted and alternatives sought. Medical practitioners have historically been male and worked full-time. Their wives have often stayed at home and taken on the role of primary caregiver thereby making it easier for GPs to work long hours (Finch, 1983; Fowlkes, 1980). In this way, dominant ideas about gender roles and medical work practices have been reproduced. However, as growing numbers of women in medicine resist these dominant work patterns, their calls for counter-hegemonic work practices question Gramsci's (1999: 12) notion of an unconscious, 'spontaneous consent' to norms in social relations espoused by the dominant group because of its position of power and leadership within the social order. Many women are refusing to agree to work patterns that do not meet their needs. Such resistance also highlights Bourdieu's notion of proactive 'agent' where women may redefine their role to better serve their interests rather than passively complying with how it has been constituted to serve the interests of the dominant group.

It is at this point that I examine gender as social practice more specifically in the context of relationships of power in the social organisation of the family and medical practice.

### **Gender as social practice**

The notion of gender can be understood as a structuring principle that is played out in social practice. Connell (1987; 1995; 2002) draws on the idea of hegemony to examine the relationship between structure and social practice to help understand gender relations. He argues that the inequitable distribution of power is an important aspect of the structure of gender relations. This is evident in how roles are negotiated and experienced in the family in relation to the division of labour. However, Connell (1987: xiv) resists any attempt to clearly define gender roles that might belie their complexity or the 'sheer intractability of gender relations'. He does concede that, notwithstanding the multiple ways masculinity and femininity are depicted, there is an ordering principle, however circumscribed, governing gender relations in society that reinforces men's dominance over women.

Structural factors can be seen to reproduce gender relations that serve the dominant group's interests by encouraging and affirming individual and collective action that supports those interests at the level of practice. This position evokes beliefs, values and ideas that maintain male dominance within social institutions. In this way the concept of hegemony as a structuring principle shapes ideas, beliefs and values about what constitutes 'normal' social practice in subordinate groups in the context of gender relations.

Power in gender relations is institutionalised in the medical profession and the family. The work practices of female GPs are often subordinated to those of their male colleagues. In the home, female medical practitioners may support their spouse's role as provider and often take responsibility for the caregiving role in the family on top of their medical workload (Crompton & Le Feuvre, 2003; Lapeyre, 2003). The more diffuse nature of power in gender relations is evident in broader discourses on how women are represented. Often such discourses reflect a more intimate, pervasive illustration of hegemony that affects an individual's sense of identity and place within the social order (Connell, 2002: 36). A case in point is the dominant portrayal in the media of dominant ideas about the position of women in relation to men. Desirable women in many TV commercials are those who conform to such ideas by being beautiful, young and thin or, if they are mothers of young children or teenagers, attractive, competent caregivers in the home, even if they work full-time. Connell (2002: 59) suggests that a relationship exists between power operating through institutions such as the family and discursive power. He draws on Foucault's ideas who argued that power operates discursively where it is diffused through language, both speech and text. This form of power is more intimate. Both aspects of power inform or reflect each other and influence the social practice of gender.

People's expectations and experiences lived out on a daily basis serve as a 'site' for compliance with, or resistance to, hegemonic ideas, beliefs, and values embedded in social institutions or in contexts where power is more diffuse. The dialectical relationship between structure and social practice is revealed when such ideas and values are contested, opening the door to other possibilities of practice (Connell, 2002: 9-10). Tension within this relationship is present when female medical practitioners contest dominant ideas supporting an

heroic commitment to long working hours. Their choice to approach work practices differently challenges the conventional medical work ethic, causing discontinuity that undermines dominant beliefs but can lead to change. According to Pringle, women's resistance is not accompanied by any notion of revolutionising medical practice:

Women did not self-consciously or as a unified group set out to transform medicine but their presence is producing changes beyond what any but a tiny minority may have ever visualised (Pringle, 1998: 222).

Structural changes have occurred where conventional approaches to medical work practices are being reconsidered to meet more effectively the needs of growing numbers of women in the medical workforce, many of whom want to balance the competing demands of work and home (Pringle, 1998). However, compliance with hegemonic ideas is contextual and not necessarily transferable across settings. Consenting to dominant ideas in one setting may require resisting them in another. In order to meet dominant expectations of their role as caregiver in the home, women may opt for more flexible hours in the workplace. This theme will be examined later in the thesis.

The dialectical relationship between structure and social practice is also revealed in the tension and frustration many GPs feel in response to economic and political changes impacting on their work practices. The interests of the medical profession in maintaining control over its work practices intersect with government policy that fosters financial deregulation, competition for services and cost effectiveness. Health reforms requiring increased accountability from the medical profession may undermine doctors' autonomy and control over their work practices. Resistance from medical practitioners to such 'guidance' may cause tension that can lead to changes in structural patterns. However, tension can also emerge when medical practitioners consider they have little choice but to conform to such structural requirements. In this case, the work practices of medical practitioners change in light of structural constraints.

### **Political and economic changes and rural general practice**

Critical medical anthropologists Baer (1986) and Singer (1990; Singer & Baer, 1995) also argue that wider structural elements affect social practice. They

suggest that State support of a medico-centric approach to providing health care is linked to hegemonic beliefs and patterns outside medicine. These include political and economic factors where interests serving dominant groups underpin power relations. State support for neoliberalist principles may conflict with the interests of the medical profession at the level of practice, reflecting the hegemonic position of the State in shaping medical practices, a theme discussed later. Yet, State support for neoliberalist ideas intersects with a medico-centric approach to health service delivery reflecting, at another level, the alliance between the medical profession and the State. Examples of this alliance include government allocation of health resources that supports the construction of medical solutions to the rural health problem where the answer to better health care in rural communities is often seen as supplying more doctors (Abbot, 2004; Kamien, 1987; Keleher, 1999; Strasser et al., 1997), and the dominant position of the medical profession in relationships with other health professionals (Freidson, 1970; Germov, 2003a; Willis, 1989). Health care is often subsumed under medical care which, with its curative focus, gives less priority to other causes that may determine an individual's health such as socio-economic factors (Baer, 1982; Humphreys, 1985; Nord, Richardson, Street, Kuhse, & Singer, 1995).

Determining the interplay of power in relationships between the State, the medical profession and the consumer helps to explain how hegemonic ideas about health care 'inform interpersonal relationships, shape social behaviour, generate social meanings and condition collective experience', and come to be accepted as the norm within society (Singer, 1990: 181). In forming a consensus supporting a medico-centric approach to health care which is seen as common sense and part of conventional wisdom, groups or individuals may misrecognise relations of power and control that subordinate other approaches to health care. Indeed, resistance to dominant views on health care is constrained by 'hegemonic messages confirming the given-ness, indeed the naturalness of the existing social order' (Singer & Baer, 1995: 344).

Such a process reflects the dialectical relationship between structure and social practice by pointing to the diffuse and discursive nature of power in social relationships that is 'localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local, covert level through sets of

specific practices' (Turner, 1997: xi). However, such power may be resisted, with the result that structures or practices can change. Doctors have enjoyed a long period of prestige and autonomy where their expert knowledge, strong relationship with the State, and the dominant position medicine holds in the area of health, has withstood contest from other health occupations (Freidson, 1970; Willis, 1989). The 1970s and 1980s saw the medical profession at the height of its dominance and power in matters related to health (Alexander, 2000; McKinlay & Marceau, 2002). Politically, its authority as expert in health and its ability to direct health policy continues to be recognised and acted upon. Economically, its capacity to determine its fee for services rendered is accepted, and clinically, it persists in subordinating other health professions to its control (Elston, 1991). The medical profession has also exercised autonomy in clinical practice. Its organisational structure operates independently of its management structure in relation to health reform and, even though it advises management, it has not been held accountable for the implications of decisions regarding health expenditure (Alexander, 2000).

White (2002) suggests that, at the level of practice, medicine, power and knowledge have co-existed, manifesting as a form of hegemony where a medico-centric approach to health care is accepted as the norm. Historically, the medical profession's power to exercise authority over other health occupations and shape society's beliefs about managing health problems have had important implications for health policy (Palmer & Short, 2000; Willis, 1989). Any threats to its dominant status, such as challenges to its autonomy, calls for changes to its fee structure or moves to expand the roles of other health professionals, have often been fiercely defended by medical practitioners (Palmer & Short, 2000).

Yet while the medical profession still dominates the health division of labour 'economically, politically, socially and intellectually' (Willis, 1989: 2), the strength of its position is weakening in light of political and economic changes. The Commonwealth government is seeking competitive and cost effective practices in health service delivery and, together with health consumers, is calling for doctors to be more accountable and transparent in their clinical practice. Promoting evidence based medicine is one strategy to assess the effectiveness of medical interventions. However, such State intervention in

clinical practice has often caused tension and frustration amongst many rural GPs who feel their autonomy and control over their work practices are being undermined (Palmer & Short, 2000; Strasser et al., 1997; Wainer, 2002). Despite the tension and frustration rural GPs experience, many are changing their practices and conforming to structural requirements.

Having provided a theoretical backdrop in which to examine the dialectic between structure and social practice in the context of rural general practice, I now review research findings on gender relations and political and economic change. My aim, in light of this project, is to address factors affecting the actions, expectations and experiences of rural GPs and their spouses and their decision to remain in a rural location.

### **Situating the study**

This section of the chapter extends theoretical ideas discussed earlier in specific contexts. First, it draws on studies to examine the impact of structural changes on social practice in the context of gender relations in the rural medical workplace and in the home. Second, it explores the effects of a changing political and economic climate on the autonomy and control the medical profession has historically exercised over its work practices. These perspectives offer a broader analysis within which to consider the future supply of a rural medical workforce.

### ***Feminisation of medical profession***

The institutional structure of many professions has been organised to reflect a gendered division of labour predicated on the male in the workplace as provider and the woman at home caring for the family (Fowlkes, 1980; Rhodes, 2001; Wise et al., 1996). While this division is changing in the workplace generally, with organisations in Australia introducing family friendly provisions such as flexible hours for childcare, few fathers are taking this up (Bittman et al., 2004). In rural general practice, hegemonic beliefs underpin the high ideals of the 'medical sublime' espousing medicine as a vocation involving a commitment to work '24 hours a day, seven days a week' (Pringle, 1998: 2). The social organisation of medicine, like other professions, originally evolved to suit men in conventional family constellations with the male as provider working outside the

home and the female remaining at home to take on domestic and childcare responsibilities (Hochschild, 1989).

However, more women than men are currently entering the medical profession in Australia (Wainer, 2003). Many choose to work flexible hours effectively challenging the 'medical sublime' and evoking resistance from within the medical profession (Pringle, 1998: 10). While some in the medical profession welcome the growing numbers of women, others resent their intrusion. They see women doctors as a 'subaltern' force, not 'real doctors' because they do not conform to the demands of an heroic work ethic and therefore cannot be seen as 'serious about their career' (Pringle, 1998: 181).

Few female medical practitioners over the years have felt that the medical profession's organisational structure has met their needs (Game & Pringle, 1983; Witz, 1992). Moreover, women have worked hard to accommodate hegemonic work practices while attempting to balance the demands placed on their time by their commitments in the home (Crompton & Le Feuvre, 2003). Working long hours has been difficult for female GPs given that many are also the main caregivers in the home. Findings from the *National Rural General Practice Study* (NRGPS) revealed that models of work practice involving inflexible, long hours were unappealing to female GPs who preferred a less rigid approach to the issue (Strasser et al., 1997). According to Pringle (1998: 3), this is not to suggest that women doctors should be placed in a position of 'marginality or victimhood'. Instead, Pringle argues that the sheer force of their growing numbers in medicine, their presence and speech, *are* destabilising the organisational structure of medicine. Nonetheless, as agents, female GPs also have the potential to transform work practices by not internalising constructed realities that do not serve their interests.

However, while women GPs may not be victims to their circumstances, hegemonic beliefs do constrain their practices. Female rural GPs are working in a profession whose skills, education and occupational position in the social order are highly valued and endowed with much status and prestige, reflecting its dominance. Within the profession itself, the negative responses of some male GPs to their female colleagues working part-time to meet their family

responsibilities (see Clearihan, 1999), suggest that status and prestige within the profession is contingent on conforming to hegemonic, male work practices to ensure they are reproduced. Female doctors who do not accept this work ethic are often treated with disdain by their male colleagues. Effectively, they are subordinated to their male colleagues because their work practices are not constitutive of being 'real doctors' (Pringle, 1998: 10). Such a response implies a form of symbolic violence given the negative effects on female GPs of work practices that only seem to value full-time commitment even though many female GPs are attempting to balance their dual roles between home and work.

However, as Connell (2002) and others argue, the dominance of one group over another is never total. The institutions that create that dominance also create the conditions for resistance. In a gendered context, power is contested when male dominance is resisted and, as a result, often weakened, a process that can occur institutionally and discursively. Many female GPs are resisting models of work practice that conflict with their own approach to practising medicine by working within a framework that supports an holistic approach and allows more flexibility in working hours (Kilmartin, Newell, & Line, 2002; Lippert & Tolhurst, 2001; White & Fergusson, 2001).

Yet female doctors' resistance to working long hours is often predicated on their wish to fulfil the demands of their role as main caregiver in the home suggesting that resistance to hegemonic beliefs is contextual. Indeed, structural constraints on the social practice of gender are problematic when transferred across contexts. This seems particularly relevant when few female rural GPs with families can meet the expectations of a male model of rural general practice when the conventional wisdom regarding the gendered division of labour in the home allocates the main responsibility for childcare and domestic tasks to women. If they become full-time rural GPs, do they forego having children, reverse roles with their partners or negotiate gender practices? In this context, to what extent are male spouses willing to re-structure their work practices to allow negotiation of responsibility for childcare and domestic tasks in order to combine the professional and career aspirations of both members of the couple in a way that is experienced as fair?

More male than female rural GPs are married or in committed relationships (Strasser et al., 1997). Most rural female spouses are the primary caregivers and are often supported financially by their GP partners (Nichols, 1997; Wise et al., 1996). Limited research is available on the expectations and experiences of male spouses of rural GPs. Nichols (1997) and Wise et al. (1996) suggest that in relationships where the female works as a rural GP, male spouses often conformed to expectations of their role as provider, generally working full-time in their original profession (Nichols, 1997; Wise et al., 1996). Research on female GPs in Britain and France shows that they conform to conventional social expectations and make choices during their training which assume they will take responsibility for the family and the home, which they frequently do (Crompton & Le Feuvre, 2003).

### ***Gender relations in the home***

Women who accept their role as primary caregiver as ‘normal’, even if it means relinquishing their own professional or educational aspirations, are reproducing hegemonic beliefs about gender relations. Female spouses of medical practitioners often feel they take second place ‘in relationship to both the status and the time demands of their husband’s work’ (Fowlkes, 1980: 82. See also Wise et al., 1996). In a rural medical context, many marriages or long-term partnerships have adopted conventional gender roles in the division of labour. The structure and organisation of men’s work often constrains the choices of women, particularly if they are financially dependent on their spouses and are expected to fit in with the demands not only of their husband’s occupation but also his leisure activities (Dempsey, 1990, 1992; Finch, 1983; Rhodes, 2001).

While this works well when women are prepared to accept the major domestic responsibility and provide support and respect for their husband’s demanding career, it does not necessarily generate happy marriages. Many of these marriages, whilst enduring, have not always been fulfilling (Gabbard, Menninger, & Coyne, 1987; Hall Yandoli, 1989; Nelson, 1978; Sakinofsky, 1980). Indeed, women may misrecognise that inequity in the division of labour, limited opportunities to meet educational or occupational aspirations outside the home can constitute a form of symbolic violence. Indeed, even when women also

provide economically for the family, beliefs and values reinforcing their supportive, caring position in relation to men's dominant role as provider may be strong. In response, many women may choose to comply with conventional gender role expectations even if it means they also work the 'domestic shift', often with limited assistance from their male partners. This has not been without cost. The more pervasive emotional effects of socially constructed gender roles are seen in an unpublished study of 107 doctors' wives in the United States. Harding (cited in Miles, Krell, & Tsung-Yi, 1975: 483) found that 77 per cent reported unhappy marriages with 92 per cent indicating their emotional needs were not met by their husbands. Research on suicide in England and Wales revealed five times as many doctors' wives as architects' or accountants' wives, committed suicide (Sakinofsky, 1980). A study of twenty doctors' wives in Canada showed that eighteen were unhappy, depressed and angry enough in their marital relationships to have had suicidal thoughts (Miles et al., 1975). In the United States, a survey on sources of conflict in marriage showed that 68 per cent of physicians and 65 per cent of spouses in the sample had either sought or considered marital counselling (Gabbard et al., 1987).

Although these studies are not recent, they offer evidence that hegemonic expectations of gender roles which are internalised as common sense or part of the 'normal' social order can have negative consequences. Women can misrecognise the symbolic violence being perpetrated even if it damages their health. Yet women's reluctance to seriously question inequities in gender relations helps to sustain and reproduce such patterns. A fundamental inequity in an organisational structure that prioritises the needs of men while disadvantaging those of women is evident in the medical profession and in some medical marriages. In order to adopt the role of primary caregiver, female GPs may choose to work part-time, and female spouses of rural GPs may choose not to work at all. They may subjugate their own aspirations for fulfilment outside the home and take responsibility for childcare and domestic tasks in order to support their male partner in his role as provider.

Feminists have attempted to show how women are subordinated and exploited in the gendered division of labour at home and in the workplace (see Bernard, 1982; Hochschild, 1989; Oakley, 1985). Marxists might assume that

exploitation can lead to resistance and revolution (MacKinnon, 1997), yet more recent research has shown that many women refute the claim they are being exploited. Instead, they view their husband's treatment as just and their own contribution to childcare and domestic tasks as fair (Dempsey, 1992, 1997a; Hakim, 1995, 2003b). Indeed, many wives of professionals, rather than seeing themselves as 'helpless victims of patriarchy, masculine oppression or marital inequality' (Rhodes, 2001: 352), embrace their supportive, caregiving role where their 'subservience is reinforced culturally and ideologically endorsing [their] withdrawal from the search for personal fulfilment beyond the home' (Rhodes, 2001: 353). Wives of professionals reflect their 'doxic' or uncontested acceptance of the social order as something normal and natural and misrecognise the symbolic violence present in the inequitable distribution of power in gender relations that subordinates their needs and aspirations. As long as the marriage or relationship is maintained and/or women reap the benefits of their conformity to hegemonic expectations such as social acceptance, financial security and social status the effects of women's subordination remain hidden. If the relationship breaks down, such effects are revealed as the standard of living, social status and career prospects of women drop while those of their husbands often rise significantly (Delphy, 1992).

Gender relations are set against a backdrop of social change where other structural elements are also impacting on social practice. Shifts in the political and economic climate are affecting the work practices of rural GPs often causing tension and frustration. Perceptions of the nature of health and illness, health policy and resource allocation and the role of the State in health care are changing (Singer & Baer, 1995: 60) with corresponding changes to medical work practices.

### ***Effects of political and economic change on medical work practices***

Changes in the political and economic climate are occurring in many Western industrialised countries including Australia because of the shift away from the principles of social welfare and towards those of neoliberalism (Rodger, 2000). Since the mid 1980s reforms to health care systems emerged as a major concern notwithstanding their differences in cultural, political, social and historical contexts (Chernichovsky, 1995). In most industrialised countries, the

welfare state as a means for redistribution and social protection has been wound back and superseded by a neoliberalist agenda (Rodger, 2000). A neoliberalist, or economic rationalist, position holds that the market is not only the best allocator of resources in an economy, but is seen as the ‘only legitimate allocator of goods and services in society at large – not just the economy’ (Battin, 1991: 296). Neoliberalists advocate reducing the size and power of the government and the public sector (Melleuish, 1997: 203) and promoting the notion of competition between organisations in the marketplace (Peck & Tickell, 1994). Cost efficiency and competition are seen to be more effective when individuals, not bureaucracies, are free to decide their own needs and set their own goals and priorities (Melleuish, 1997). This, according to Peck and Tickell (1994: 318), has led to an ‘explicit rejection of both the social partnership and traditional forms of welfare-ism’.

In Australia, neoliberalist policies have supported this type of economic restructuring and reform which has constituted a significant move away from the post-war welfare policies (Beeson & Firth, 1998; Hindess, 1998; Rees, 1994). As a result of this shift, health care has become a commodity to be bought and sold. Individuals’ rights and responsibilities to make their own decisions about health care and the efficiency of allocation of health services take precedence over government, social and economic regulation (Duff, 2001: 31). Gone are the days of Australians viewing health care from an egalitarian perspective as a social good free from economic values (Latham, 1994) where health care was seen as a right rather than a privilege (Humphreys, 1985). In the current climate, governments have reduced services and shifted some of the burden of meeting health and welfare needs to private markets (Duff, 2001).

This change raises an interesting conundrum in the context of hegemonic relationships. Pre-existing alliances between the State and the medical profession that have reproduced hegemonic ideas and practices are being challenged by a powerful third party, the market. The coalition between the State and the market that supports neoliberalist principles informing resource allocation for health funding rests less on the State’s loyalty to its alliance with the medical profession and more on policies promoting competition and cost effectiveness. Such a potential threat to the strength of the State/medical profession alliance reveals a

tension between these dominant structures. At the end of the day, the medical profession's struggle to maintain its strong alliance with the State is being undermined by the State's infatuation with market forces. Even though the medical profession's most 'strategic and treasured' possession is its autonomy, it is the State that has ultimate autonomy' (Freidson, 1970: 23) when it comes to the organisation of health services.

Some studies argue that the medical profession is weathering the storm without any noticeable dents to its power base. Freidson (1994 cited in Germov, 2003a: 301) suggests that it has responded to structural changes without succumbing to major threats to its power. While the autonomy of individual doctors is increasingly constrained by bureaucratic and corporate requirements as well as by informed consumers questioning their expertise, Freidson argues that the collective autonomy of the medicine as a profession remains intact. However, Kuhlmann (2002) suggests that expert knowledge and practices in health care systems are being re-negotiated in a climate where professional boundaries are becoming more porous. Collaboration, teamwork and flexibility amongst professionals are favoured over the hegemony of the autonomous solo practitioner reflecting the need to research the professions in a context of social and cultural change to better understand those influences. While such changes are not heralding the end of professionalism, Kuhlmann argues that the role of the medical profession in a knowledge based and service oriented society needs to be redefined.

Other studies reflect on how social changes have affected the values and work practices of the medical profession. They argue that the autonomy of the medical profession in its work practices is increasingly being called to account. The dominant position medical practitioners hold in health care delivery is considered by some to be less secure as the profession goes through a period of struggle in many Western nations. The tendrils of neoliberalist principles underpinning market forces are being felt in medical work practice. Increased pressure by government to rein in health care costs, technological advances in medicine, increasingly articulate, informed consumers, the rise in litigation against doctors (Calnan & Williams, 1995; Eve & Hodgkin, 1997) and the increasing numbers of women entering the medical workforce are reinforcing

these changes. Patients, whilst becoming more demanding of their doctors, have also become less respectful and more critical (Sibbald & Young, 2001). Such developments suggest a shift in the position of patients from being passive individuals who accept the dominant position of the medical profession uncritically to becoming active agents who question practices they consider may not serve their own interests.

As a result of these overall changes, some researchers argue that the power and status embedded in the hegemonic position held by the medical profession are starting to waver (Hafferty & Light, 1995; McKinlay & Arches, 1985). The 'golden age of doctoring' (McKinlay & Marceau, 2002: 379) is declining due to structural factors including the changing nature of the State and the loss of its partisan support for the medical profession, particularly in the light of neoliberalist principles. White (2000a: 286) goes further to explain that the impact of structural requirements is weakening the power base of GPs. He claims that the current political and economic climate requires that medical practice succumb to fiscal control through cost containment and accountability in clinical practice. He suggests that this demand commodifies medical services and effectively threatens the medical profession's autonomy and control over matters related to health thereby undermining its hegemonic position. Added to this, GPs are experiencing increased surveillance of their practices by their funding sources as a result of more widespread use of technology. This concerns the profession as it sees itself caught between the State and the market. Moreover, increasing corporatisation in the medical field, such as investment corporations buying up general practices for profit, further decreases the autonomy of medical practitioners as they are required to work under the terms and conditions specified by the organisations that employ them (Duff, Larsen, Tonts, & Ainsworth, 2000; White, 2000a). Competition from other health professions to provide services previously offered only by the medical profession and a shift in focus towards medicine being seen within a business context is further diminishing its status within the community (Pearson, 1993; Sutherland & Cooper, 1992; White, 2000b).

However, not all researchers agree that the hegemonic status of the medical profession in health care delivery is diminishing. Elston's (1991: 83)

work from Britain on the politics of professional power, argues that the medical profession is making 'uncomfortable adjustments' to socio-economic change rather than such change threatening the institutionalised patterns supporting its hegemonic status in the area of health service provision. Nevertheless, Sutherland and Cooper (1992) suggest that these structural changes are leaving medical practitioners ill prepared for the challenges to their autonomy and position at top of the health hierarchy. Indeed, the dialectical relationship between structure and social practice is evident as doctors 'worldwide' are becoming 'dispirited, ... disillusioned, disinterested and despairing due to the havoc wrought by constant change and uncertainty' (Van der Weyden, 2001: 62). This sentiment was reflected in findings from the NRGP study with many doctors expressing their anger and frustration at increased government intervention in their work that required changes to their clinical practices (Strasser et al., 1997).

### ***Resistance to medical hegemony in rural health care***

Current attempts to broaden the debate on what constitutes rural health care beyond a medico centric approach have met with resistance from within the medical profession. Recent responses in the media by the medical profession to nurse practitioners taking up more responsibility have openly stated that nurses would be offering second class care to that offered by doctors. The Australian Medical Association (AMA) reiterates the dominant position of doctors in health service delivery and does not accept that nurses or nurse practitioners can replace the services they offer (Australian Medical Association, 1994). This is despite evidence suggesting that some of the work of medical practitioners can effectively be carried out by nurse practitioners with no significant difference in health outcome and quality of service (Richards, Carley, Jenkins-Clarke, & Richards, 2000). Indeed, the difficulty attracting GPs to fill positions in rural centres has opened the door to considering alternatives to health care provision. The increasing clinical autonomy and expertise of nurse practitioners, who are registered nurses working in an advanced clinical role, has led to them being able to practise independently under strict guidelines, notwithstanding stipulations from the medical profession that they work only in areas of need where a doctor cannot be found (Wicks, 2002). Registered nurses and Aboriginal health workers

also offer a restricted range of health care services in some rural centres which, in a city, would be provided by general practitioners (Strong et al., 1998).

While this practice is not new, the difference is in the voice of other health professions wanting changes to the medical dominance of health service delivery. These changes would include a greater acceptance of role flexibility and multi-skilling between medical and health professionals in the provision of health services in rural areas (Pearson, 1993). According to the Western Australian state government report *The Country Health Services Review* (Department of Health, 2003: 34) an 'excellent example of adaptive workforce strategy' to the problem of recruiting and retaining rural GPs would be to employ nurse practitioners. These health professionals would 'help to retain a good range of local health care for small rural communities that are unable to attract and retain a resident GP'. Such trends are reflected in medical workforce planning initiatives. These include new models of care where tasks are allocated to other health professionals thereby changing the market for medical services. However, a strategic approach to a skills-mix is yet to emerge (Duckett, 2004; Joyce, McNeil, & Stoelwinder, 2004).

Notwithstanding the increasing influence of market forces and shifting trends in medical workforce planning, the hegemonic alliance between medicine and the State persists at this point in the context of rural health service delivery where the consensual understanding of optimum health care privileges the role of medical practitioners. The dominance of a medico-centric approach is still reflected at a policy level where non-medical strategies, such as allocating resources to help rural communities create and promote health by strengthening the necessary infrastructure, are side-lined (Keleher, 1999). The medical profession has reproduced hegemonic beliefs by generally resisting any expansion of the discourse on health care beyond a biomedical approach to one that includes a broader vision for the health and social future for rural Australia (Keleher, 1999). Some health professionals argue that this response to rural health care implicitly undermines the role and value of the non-medical, rural health workforce and thwarts any idea of a level playing field between health and medical professions competing to provide services in the spirit of neoliberalist principles. According to one Australian rural pharmacist:

There needs to be a very clear and unashamed commitment to the non-medical workforce...At present almost all the emphasis has been on medicine...money [has been spent] and programs established for GPs and their families...the rest of the health professions being very poor cousins by comparison. The politicians need to look beyond medicine and they have to put some serious money into nursing, pharmacy and other health professions. It's a great model but there is more to the health workforce than doctors (National Rural Health Alliance, 2004: 10).

These comments raise another question about whether better health is contingent on appointing more doctors or adopting a broader approach to the health issue. Keleher (1999) argues that, to improve the population's health, the medical profession has long promoted the idea that more doctors are needed in rural locations. Yet in 1996, almost double the number of medical practitioners provided services in metropolitan centres compared to some small, isolated rural areas (Strong et al., 1998). In 2000, estimates of the shortfall of GPs in rural areas in Australia ranged between 750 – 2000 leaving rural areas with fewer GPs despite initiatives to encourage GPs to practise outside capital cities. The ratio of 144 medical practitioners per 100 000 people in rural Western Australia falls far short of the average 260 per 100 000 for the Australian population as a whole (Australian Institute of Health and Welfare, 2000). According to Boffa (2002: 303) over-servicing the wealthiest in Australia is unacceptable while the poorest and those with the worst health status, often Aboriginal Australians in isolated rural areas, have great difficulty accessing GPs to meet their needs.

Suggestions to help correct this imbalance have been framed within the biomedical paradigm. They have included providing more students places in medical schools and increasing the number of overseas trained doctors working in Australia (Australian Medical Workforce Advisory Committee, 2004b; Australian Rural and Remote Workforce Agencies Group, 2004). A more controversial suggestion has been to change the distribution of Medicare provider numbers which are currently allocated to doctors who have fulfilled the requirements for registration with state medical boards. This solution arose because most GPs choose to practise in cities, a choice that leaves many rural areas under-serviced or without a GP. Ideas for reform include restricting provider numbers to an equitable, agreed-upon ratio of the distribution of GPs to

population. In areas of high morbidity, this ratio would need to be higher than the national average based on need (Boffa, 2002). Alternatively, provider numbers could be re-allocated based on geographic areas of unmet need (Hamilton, 2001). According to Boffa (2002) AMA resistance to these proposals is a major reason preventing more equitable access to GPs for some Australians. As a result, many private practitioners continue to operate in locations where the profits are highest, rather than on the basis of greatest need for their services. Until governments are willing to regulate their choice of location more equitably to ensure effective coverage in all areas, the situation of inadequate and inequitable allocation of medical resources is likely to continue (Humphreys, 1985). Attracting GPs to live and work in rural areas has been made more difficult by the negative effects of political and economic change on rural restructuring and development that have done little to make these areas more appealing to GPs and their families.

### ***Rural restructuring and development***

Neoliberalist principles informing changes to public policy are underscored by the belief that the extension of free markets will benefit everyone and lead to welfare reduction. However, according to Gray and Lawrance (2001), such ideas are social constructions that serve the vested interests of the powerful, not least global corporations who determine the future of rural Australia. Those living in rural areas have little access to such corridors of power and instead rural society in Australia is 'saddled with limited reflective capacity and interminable powerlessness in its relationship with metropolitan Australia' (Gray & Lawrence, 2001: 182) reducing its options and perpetuating rural/metropolitan inequities.

Restructuring rural communities in Australia, where demographics and infrastructure have been reconfigured, is set against a backdrop of neoliberalist principles underpinning political and economic decision making (Battin, 1991; Hindess, 1998; Rees, 1994). Market forces are given more freedom as deregulation and privatisation replace government subsidies and intervention (McKenzie, 2003). Images of the rural idyll where the Australian bush is synonymous with intimate, rustic communities have been replaced by pictures of crisis and conflict over the contentious effects of such policies on those living

and working in rural locations (Lockie, 2000). Social and economic decline in rural areas has been precipitated by reduced commodity prices, metro-centred social and economic policies, out-migration of local populations, and changing ownership patterns of rural economic enterprises (Cocklin & Alston, 2003).

Australia's rural research programme also prioritises economic efficiency over social needs in rural communities (Black et al., 2000), with insufficient attention being paid to the inequitable impacts of rural restructuring in government policy (Fagan & Webber, 1995). Policies focusing on cost cutting and competition have led to essential services being withdrawn, threatening the identity and viability of many towns in rural Australia (Tonts, 2000). This significantly affects the wellbeing of the local populations (Black et al., 2000; Tonts, 2000) particularly given that the availability of services is a significant contributing factor to community sustainability (Cocklin & Alston, 2003: 2). Many public services have either been reconfigured to be more cost effective or sold to the private sector (Black et al., 2000) where their resources are consolidated in larger rural centres. This change has had a significant impact on smaller rural centres due to difficulties accessing those resources because of distance. As central government reduces subsidisation schemes, local government and agencies in large rural centres have picked up the tab for attracting industries to local areas (McKenzie, 2003).

These structural changes have left many rural locations in Australia struggling to attract and retain GPs in an environment where health care provision is woefully inadequate compared to services offered in metropolitan centres (Australian Institute of Health and Welfare, 2002). The drive for capital accumulation, cost effectiveness and profit conflicts with the health needs of the general population (Baer, 1982; Humphreys, 1985). The new paradigm in healthcare reform in Western industrialised countries has been implemented to develop a satisfactory private/public mix to promote equal access to a basic health care package (Chernichovsky, 1995). However, the notion of equal access to a basic health package in rural Australia is questionable when compared to services offered to those living in metropolitan areas. Cost cutting has led to reduced access to health and welfare services particularly more isolated rural

areas where economies of scale make viable commercial operations difficult (Duff et al., 2000).

The effects of the shift away from social welfare policies are reflected in a substantial body of evidence pointing to poorer morbidity and mortality rates among those living in rural locations. Such evidence justifies the need for a reassessment of what constitutes 'equitable' health care and how to appropriately meet that need (see Australian Institute of Health and Welfare, 2002). The health industry is now seen as an institution governed by economic logic rather than social welfare where 'self-interested action' is seen as a 'better guarantor of social progress than any traditional norms and values' (Davis, 1993: 121). Indeed, reforms related to health care and rural development and restructuring have reduced access to health care and other services in some instances. They have also further burdened rural communities with the emergence of a 'moral' framework where the individual rather than society is expected to take more responsibility for their health and welfare needs (Latham, 1994; Rodger, 2000). In a social climate where the gap between rich and poor is purportedly widening, the effects of dominant ideas about health care based on economic logic rather than social welfare are seen in the health status of rural residents compared to their metropolitan counterparts, seriously questioning the notion of a common good. It is against this political and economic backdrop that GPs are being recruited to work in rural locations.

### ***Effects of social change on rural medical service provision***

In Australia, the picture painted of GPs' experience of rural general practice shows their professional autonomy, independence and their ability to practise a variety of medical and procedural skills (Lawrance, 2001), opportunities often not available to urban GPs. This image of rural general practice, whilst realistic in part, has been affected by political and economic changes. Such changes have added to the sense of uncertainty and frustration many rural GPs feel. Many smaller country hospitals have been downgraded in the services they offer, resulting in limited opportunities for GPs to practise their procedural skills, regardless of their qualifications and experience.

Negative aspects of political and economic changes were also reported in findings from a qualitative analysis of the *National Rural General Practice Study* (Wainer, 2002). Many rural GPs resented the financial stress and loss of professional autonomy resulting from shifts in government policy. They were angry at being caught in a profit squeeze between static incomes and rising costs and at any threat of a federal government freeze on Medicare rebates. Such action would adversely affect their incomes particularly in light of rising costs in practice management and medical insurance. Concern about threats of medical litigation affected how they practised medicine, including their relationship with their patients, and reduced their enjoyment of work.

Rural GPs were also angry and frustrated that increasing bureaucratic surveillance and government intervention in clinical practice were eroding their professional autonomy. Many GPs abhorred the bureaucratic intrusion into their work practice and there was an ‘underlying simmering resentment at the controls being imposed on doctors and the requirement to conform to imperatives other than clinical judgement’ (Wainer, 2002: 20). Economic downturn in rural environments reflected in many services being withdrawn, contributed a pervasive sense of negativity about rural general practice leaving many GPs feeling frustrated and exhausted (Wainer, 2002).

Locating the recruitment and retention problem within a broader structural context reveals that GPs may not consider that the impact of political and economic changes on clinical practice serves their interests; instead it often leads GPs to feel tense and frustrated. At another level, structural constraints intersect with the autonomy and control of the medical profession. This is evident in the current drive for cost effectiveness that may conflict with the power of the medical profession to determine its own work practices. In this light, competition from other health professionals to provide services once only offered by doctors is legitimated by health policies supporting neoliberalist principles. Indeed, other health professionals are providing services in areas unable to attract GPs, thereby opening the door to considering alternatives to a medic-centric solution to the problem. While the medical profession may no longer be considered ‘the sole repository of legitimate medical knowledge’ (White, 2000a: 286), the issue of recruiting and retaining rural GPs becomes a

‘site’ where hegemonic views about rural health care are being contested. Many rural GPs are struggling to come to terms with the effects of these changes that are causing tension in rural GPs’ relationship with the State.

Tension is also evident between the medical profession and other health professions where registered nurses have filled the gap as total health care practitioners ‘when it has not been possible to retain the services of medical practitioners’ (Pearson, 1993: 215). While some argue that nurses want to take over the doctor’s role by becoming surrogate GPs, others suggest that nurses are being exploited when assumptions are made that they will carry out that role in the absence of medical practitioner (Hegney & McCarthy, 2002). Renegotiating roles in a context of diverse rural health services can benefit the overall needs of the public. According to Keyzer (1997: 187), advanced nursing practice involves a higher level of clinical decision making and integrates ‘practice, education research and management into [advanced nurse practitioners’] daily work’. It is the ‘old order’ of the health care system that needs to be open to change whereby the skills of other health professionals can be successfully employed as part of the goal of improving standards of rural health:

Rural doctors have more to fear from holding onto past practices and outdated attitudes than they have from developments in nursing practice. This is a time for collaboration between rural nurses and doctors to promote healthy rural communities (Keyzer, 1997: 188).

Indeed, preserving a medico-centric approach to rural health can be problematic for several reasons. It can deflect from addressing the complexity of issues underlying rural health that relate to broader structural determinants such as political and economic factors. The effects of such factors impact on rural communities and can affect the success of recruiting professionals. They, like local community residents, face challenges such as limited infrastructure, inadequate services, fewer opportunities for professional development, a less diverse culture and lifestyle and diminishing populations because of out migration (McKenzie, 2003; Tonts, 2000), that may make working as GP in a rural location less attractive. Rather than tackling some of the broader issues underlying recruitment and retention by adequately resourcing improvements to

areas such as infrastructure and services in rural locations, governments take a different route. They focus on making rural general practice more attractive by offering generous financial incentives to GPs and their families that are not available to most other professionals or workers. Such a response reproduces the inequity between health professions reflected in the privileged position and status the medical profession holds in the health system and within the community. Hegemonic ideas regarding rural health care are reproduced in the belief that '[m]ore than ever in rural communities, what patients want is a local doctor' (Humphreys & Rolley, 1998: 940).

The notion that rural areas are deficient in what they provide for GPs and their families is reflected in governments offering financial incentives to attract GPs to work in rural locations, as if to compensate for what is lacking. While rural restructuring and development have had negative effects on some rural areas, the choice to compensate doctors does not examine whether it is the expectations of GPs and their spouses that are unrealistic in how they view life and work in rural locations. It presumes, instead, to improve conditions in their immediate environment to better meet those expectations such as offering a high standard of housing often at no cost to the GP but at considerable expense to the community with no guarantee that the doctor will stay (Mills, 1997). Doctors are provided with generous incentives to work in rural locations, incentives that are not often offered to others, suggesting that the relationship between the medical profession and the State, while undergoing changes, remains strong. Health policies in Australia continue to reproduce the dominance of a medico-centric approach to rural health care many of which are designed to induce doctors to practise in rural areas (Australian Government Department of Health and Ageing, 2004; Palmer & Short, 2000). Less emphasis is placed on examining a broader approach that would acknowledge diversity between rural areas and assist communities to improve the infrastructure that can promote health, as well as making rural towns more attractive places in which to live and work for all professionals and workers. The diversity of health needs between rural communities, and innovative approaches to health care provision have been subsumed under a 'one-size-fits-all' approach.

This raises the question of how the concept of 'rural' is represented. Differences between communities and regions are often ignored in research on rural health care needs. Health care needs become essentialised and subsumed under the banner of homogeneity. Diversity, whether in geographic location, class, age, ethnicity, race, educational status and employment opportunities, is effectively ignored (Chesters, Han, Strasser, & Ballis, 2001). Restructuring and redevelopment of rural locations has magnified diversity between rural locations: inland areas may be suffering economic decline, withdrawal of services and out-migration of young adults at the same time that attractive coastal areas are booming (McKenzie, 2003). One recent study on attracting and retaining professionals in non-metropolitan areas in Queensland found that solutions that worked in one area were not always transferable to another (Miles, Marshall, Rolfe, & Noonan, 2004). Acknowledging differences opens the door to finding innovative and appropriate solutions to meeting the rural health problem.

Evidence suggests that a national approach to recruitment and retention of professionals is needed that acknowledges diversity between rural centres and rural communities. This would involve collaboration between local, state and federal government authorities as well as professional groups, universities and development and community groups in large rural centres to develop a more customised approach to meet the diversity of needs. The participation of communities in this process heralds the importance of integrated attempts to find solutions to this complex issue (Miles et al., 2004).

In the meantime, despite governments and local communities offering Australian trained rural GPs generous incentives to live and work in areas of need, GPs are reluctant to leave the cities and vacancies for rural GP positions persist. An alternative solution has been to recruit overseas trained doctors to fill the vacancies unwanted by their Australian trained colleagues. Sourcing doctors from overseas is not without its problems. Geographic, cultural, social and professional isolation contribute to difficulties facing overseas trained doctors and their families in settling into a new community. These may be exacerbated for GPs and their families from culturally and linguistically diverse backgrounds living and working in rural areas, some of whom have had to contend with local and institutionalised racism (Miles et al., 2004). Recent media coverage of

OTDs has often been negative. Media reports covered a high profile case of the alleged involvement of an inadequately trained and inadequately supervised overseas trained surgeon from overseas in the death of several patients in Queensland.<sup>6</sup> This case highlighted several issues including the need to monitor screening procedures, opportunities for professional supervision and social support for their effectiveness in protecting the public and the OTD and his/her family. Recruiting OTDs from poorer developing countries also raises ethical questions regarding their own medical workforce being depleted if they leave, threatening the viability of ongoing health programs in their countries of origin (Scott, Whelan, Dewdney, & Zwi, 2004). While beyond the scope of this project, ongoing debate is needed to adequately address the complexity of these issues.

The next section examines how well rural GPs generally are coping with the effects of structural changes at the level of practice.

### ***Rural GPs' responses to structural change***

Kamien's (1998) ten year follow-up study involving 90 per cent of the original 101 participants in the 1986 *Ministerial Inquiry into the Recruitment and Retention of Country Doctors in Western Australia* found that 63 per cent of GPs were still practising in rural Western Australia. Reasons given by those who left rural general practice included personal issues, such as their children's education, their spouse wanting to leave and feeling exhausted themselves. Rural GPs feeling worn out and frustrated were also key findings in the analysis of qualitative data from the 1997 NRGP study. The difference in the NRGP study was GPs' anger and frustration at recent changes in government policy that decreased their professional standing and autonomy over their work practices (Wainer, 2002). While rural GPs may be making 'uncomfortable adjustments' to structural changes, some are ill prepared for challenges to their power and autonomy, as discussed earlier. In terms of recruiting more doctors, Birrell (2001) postulates that the only serious incentive for GPs to relocate to rural areas is difficulties they face in establishing a viable metropolitan practice.

---

<sup>6</sup> See article in *The Age* newspaper on 11 June 2005 by Mark Todd and Tom Noble: 'Dr Death to be pursued for murder'; also, Cath Hart and Sean Parnell's article: 'Global police hunt for Dr Death clues' in *The Australian*, 20 July 2005.

Yet is this the full picture? While findings from the NRGp study showed the negative effects of structural change on work practice (Strasser et al., 1997), they also showed that the anticipated length of time GPs stayed in a rural practice is close to 20 years. My own research indicates that major structural changes in the last 30 years have indeed created tension amongst rural GPs as many struggle to come to terms with the implication of such changes on their work practices. However, this has led some rural GPs to become increasingly reflexive about their role and work practices seeing the changes as inevitable and working with them where they experience the benefits rather than the disadvantages. It has also led some to reassess the notion of balance between work and home. This process suggests a dialectical relationship between some rural GPs and the State whereby GPs' tension and frustration as they struggle to come to terms with constraints have also led to changes in ways they approach medical work practices. Other rural GPs are less optimistic with some being openly resentful of structural requirements. Nevertheless, the majority of GPs whom I interviewed were planning to stay working in a rural area with one commenting that rural general practice was 'the best kept secret'. Overall, despite 'uncomfortable adjustments' to social changes, GPs in this study were far more positive about rural general practice than other studies suggest, pointing specifically to its advantages rather than its disadvantages. This is significant in the light of recent approaches to recruitment and retention of rural GPs, a subject discussed in the next chapter.

## **CHAPTER 2**

### **Recruiting and retaining GPs and their spouses/families in rural locations**

In a survey of nearly 5000 medical practitioners in post-graduate vocational training, rural general practice was not a popular choice. It was seen as a high risk area of work made more unattractive by threats of being sued by patients and of rises in medical indemnity insurance (Australian Medical Workforce Advisory Committee, 2003: 10). Vocational training provides GPs with appropriate levels of supervised experience to ‘assure the community that they have the essential knowledge and skills to practise competently’ (Australian Government Department of Health and Ageing, 2005: 604). The above findings from the Australian Medical Workforce Advisory Committee are set alongside a pervasive image of rural health as one of decline and depression where providing more doctors is a cure (Keleher, 1999). Studies from the United States, Canada, Britain and New Zealand demonstrate that they, too, experience under-servicing of rural areas where an excess of medical practitioners work in the city (Easton, 1997; McAvoy, 2000-2001; O'Reilly, 1997; Rabinowitz, Diamond, Hojat, & Hazelwood, 1999). In Australia, medical services in many rural areas remain inadequate with governments unable to compel doctors to work in areas of need. The 1946 amendment of the Australian Constitution prohibits any form of civil conscription of medical practitioners following a successful High Court challenge in the term of the Chifley Labor Government which led to the amendment of section 51, paragraph xxiiiA.<sup>7</sup> One way Australian governments have chosen to resolve the problem is to maintain a medico-centric focus to rural health care and increase resources and incentives to support GPs and their families in the hope, not only of improving prospects for their recruitment, but also keeping them in rural locations once they arrive (Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002;

---

<sup>7</sup> See <http://www.aph.gov.au/senate/general/constitution/par5cha1.htm>

Fleming, McRae, & Tegen, 2001; MacIsaac, Snowden, Thompson, Crossland, & Veitch, 2000; Veitch, Harte, Hays, Pashen, & Clark, 1999).

Findings from other studies on medical recruitment and retention in Australia often indicate that the problem of attracting doctors lies in the rural environment. Many rural GPs consider their living conditions, the demands placed on them by the rural community and the hours they are expected to work as unacceptable (Kamien, 1987; Strasser et al., 1997; Wainer, 2002). Government responses have focused resolving such difficulties in the hope of making rural GPs' lives easier by allocating millions of dollars in incentives in order to attract GPs and their families to rural locations and to encourage them to stay (Australian Government Budget, 2003; Australian Government Department of Health and Ageing, 2003, 2004). Solutions have included providing good quality housing, offering better opportunities for spouses and ensuring adequate time off for relaxation. Notwithstanding such inducements, predictions persist of even greater shortages of GPs in rural areas (Access Economics, 2002).

As a result, a deeper enquiry into the problem is necessary. The current focus on meeting the needs of rural GPs and their families reinforces the notion that responses to rural health care must include resolving problems in the relationship between the GP and the rural environment. More broadly, this focus reinforces the idea that the problem of rural health care requires a medico-centric solution and is often defined by recruitment and retention issues. Community acceptance of this approach as the norm reflects not only the hegemonic status of the medical profession in rural health care delivery but also the strength of its alliance with the State in successfully promoting its ideas, values and beliefs about rural health care. In this light, local communities may offer generous incentives to attract and keep GPs in the area (see Mills, 1997).

However, maintaining a medico-centric focus can deflect from examining the broader determinants of health in a rural setting such as poverty and unemployment that can impact significantly on health outcomes. This is not to suggest that rural GPs consider unimportant a social model of health care that directs attention to a wider range of health determinants; neither does it imply that rural GPs consider unimportant the role of prevention of ill health through

other factors such as community participation and social reforms (Germov, 2003b). The issue under consideration centres more on the fact that rural GPs work within a model that is concerned mainly with the diagnosis and treatment of illness, or the malfunction of the body's biological systems, within a biomedical framework (Germov, 2003a). This perspective leads many rural medical practitioners to feel 'overwhelmed with the urgent' where non-emergency issues, such as population approaches to health and community education, are 'put on the back burner once the next trauma arrives' (Worley, 2004: 1). Given the effects of socio-economic changes on the delivery of medical services, the question raised is whether a biomedical approach is the most appropriate response for attaining good health care outcomes in rural communities.

### **The social practice of rural health care**

Keleher (1999) argues that improving health in a rural community is less about providing medical solutions to treat illness and more about improving health in the context of social development. She suggests that governments should allocate resources to strategies that assist communities to improve the infrastructure that can create and promote health. For this to occur, a shift in political will is needed that would allow for the development and implementation of more broadly based, permanent solutions to the problem. There are concerns that prioritising economic over social criteria will lead to the lack of sustainability of rural communities (Black et al., 2000; Haslam McKenzie, 2000; Tonts, 2000). Many young men and women are leaving town and the populations of inland rural centres in the wheat and sheep belt in Western Australia are decreasing (Tonts, 2000) despite population growth in many coastal areas (Smailes, 1995). This scenario illustrates the diversity between rural communities that governments need to examine when considering issues of equity as well as efficiency in rural health service delivery (Black et al., 2000).

One solution to the rural health problem is to increase the use of nurse practitioners. According to the AMA this is permissible only where doctors are unwilling to practise, often in the most inhospitable and isolated locations (Australian Medical Association, 1994; Pearson, 1993; Siegloff, 1995).

However, there is evidence that nurses are being ‘forced by circumstances’ (Siegloff, 1995: 116) to provide medical services in rural areas despite the lack of legal defence for nursing actions beyond the scope of nursing practice (Hegney & McCarthy, 2002). Further debate is necessary on this issue in light of social changes already impacting on the delivery of rural health services. New models of health care are being developed, funding and licensing arrangements are changing and more health professionals are competing with the medical practitioners to provide health services. Currently, some non-medical health professionals are eligible for private insurance and Medicare rebates (Joyce et al., 2004).

However, attempts to extend the rural health care debate beyond a medico-centric approach have met with resistance from the AMA which claims that medical services are a ‘matter of life and death in rural and regional areas and must be supplied 24 hours a day, 365 days a year’ (Australian Medical Association, 2001a: 4). The power of this position underpins a cultural logic within Australian society that assumes the need for a local doctor in rural locations. However, notwithstanding the difficulty attracting rural GPs, the priority given to a medico-centric approach is sometimes problematic in light of social changes that are opening the door to other ways to respond to the rural health issue.

Nonetheless, governments continue to provide generous incentives to GPs and their families in the hope that they will want to live and work in rural locations. However, trying to persuade Australian trained GPs and their families to leave the city is no easy task. Many are reluctant to adapt to life and work in rural towns which are often seen to lack the attractions of a middle-class, urban lifestyle (Kamien, 1987). Studies have often remained focused on the negative effects for GPs of working in these locations such as professional and social isolation, long working hours, limited peer support and reduced access to amenities such as choice in education for children (see Strasser et al., 1997; Wainer, 2002). The negative effects of current rural restructuring and development are also all too real in towns now struggling to remain socially and economically viable (Haslam McKenzie, 2000).

Structural changes are also affecting medical work practices which may well exacerbate the problem of providing rural GP services in future. The increasing feminisation of the medical workforce has seen the proportion of women training for general practice in Australia rise to over 60 per cent (RACGP cited in Wainer, 2004: 49). In March 2003, male GPs comprised 70.3 per cent of the rural GP workforce in Australia and female GPs 29.7 per cent (Australian Medical Workforce Advisory Committee, 2005: 241). To consider working in rural areas, many want flexibility in their working hours, jobs for their spouses and good schooling for their children (Wainer, 2004).

Overall trends indicate that, while the number of rural GPs has increased in most states over the last 15 years, there has been a drop in full-time workload equivalents (FWEs) in all states except Queensland, Western Australia and the Northern Territory (Hirsch & Fredericks, 2001). Differences in numbers of GPs to patients ranged per 100 000 population from 122.7 GPs in capital cities, 111.4 in large rural centres to 66.1 in small, isolated rural centres (Australian Medical Workforce Advisory Committee, 2000: 35). In smaller rural centres, fewer female GPs provided services and more GPs worked longer hours including more on-call (Australian Medical Workforce Advisory Committee, 2000: 9). The shortfall in GP numbers in rural areas is creating problems in meeting the demand for services.

Added to this, the male rural medical workforce is ageing. The mean age of male GPs in Australia is currently 51 years and female GPs 44 years (Australian Government Department of Health and Ageing, 2005: 120). From 1984 to 2000, the proportion of GPs over 50 years rose from 28 per cent to 36.9 per cent (Hirsch & Fredericks, 2001). The isolation and distances between locations are factors constraining the recruitment of GPs in Western Australia (Donovan, 2003). Given younger doctors' reluctance to leave the cities, such factors raise questions about the availability of a future rural medical workforce pool to cover the demands of rural general practice. Nonetheless, governments continue to allocate millions of dollars to recruit GPs to work in rural locations in the hope that they will stay.

## **Recruitment of rural GPs**

### ***Incentives for Australian trained doctors***

In the prevailing discourse on rural health, the terms recruitment and retention have often been used interchangeably, sometimes generating ambiguity in their meaning. Retention is often linked with recruitment implying that it automatically follows recruitment which may not be the case (Cutchin, 1997; Humphreys et al., 2001). Differentiating between the two terms will avoid confusion. Recruitment aims to increase the number of doctors in general practice, often using various initiatives to attract them. Retention refers to a minimum length of stay in a particular rural location although the meaning of 'minimum' is debateable and depends on who is defining it (Humphreys et al., 2001). Incentives to encourage retention are less developed particularly in the area of flexible working patterns (Leese & Young, 1999). This is significant given the increasing numbers of women entering the medical workforce wanting part-time hours.

It is readily acknowledged by the Commonwealth government that GPs are the 'foundation' of primary care in Australia (Abbot, 2004: 33) within the current system of health service delivery. The hegemonic status accorded the medical profession over other health workers has been evident in financial resources provided to various programs established by the government to assist in recruiting and retaining their services in rural locations. In the 2000-2002 budget, the Commonwealth government committed \$562 million over four years for a *Regional Health Strategy: More Doctors Better Services*, an extensive package of initiatives designed to provide more doctors and to improve health services in rural areas (Commonwealth Department of Health and Ageing Divisions of General Practice Program, 2002: 3). Given continued shortages of rural GPs the government re-funded the program in the 2004 budget to the tune of \$830 million over the next four years (see Abbot, 2004). An extensive bureaucratic infrastructure was established to implement strategies to recruit and retain rural GPs.

The Australian Rural and Remote Workforce Agencies Group (ARRWAG) was established as a national, non-government organisation funded

by the Commonwealth Department of Health and Ageing. It was set up in 2000 with agencies located in each State and Territory in Australia. Its objective was to develop and promote the recruitment and retention of GPs to rural areas in the respective state or territory the agency was located. It aimed to do this by improving the capacity of the general practice workforce to meet the health care needs of rural communities (Australian Rural and Remote Workforce Agencies Group, 2003-2004). Rural Workforce Agencies (RWAs) administer funds at a local level to deal with shortages of GPs and develop strategies to improve access to GP services. They also administer various grants to rural GPs on behalf of the Commonwealth government in the hope of retaining their services. These grants include financial support for relocation, locum assistance, continuing medical education, and initiatives to support rural GPs and their families. RWAs also deliver education to rural practitioners, help rural communities to recruit GPs and organise locums to allow GPs to attend professional development courses (Lyle, 2002).

The Rural Retention Program (RRP)<sup>8</sup> for GPs is another program that aims to encourage GPs to stay in rural general practice. The program provides financial rewards to recognise long-standing rural GPs who have provided services. Information on this group of GPs is gathered from either Medicare data or other sources. Rural Clinical Schools have also been established as part of the University Departments of Rural Health<sup>9</sup>. They provide experience in country practice and training in rural settings by offering clinical placements for medical as well as health science students, hoping to encourage their relocation to rural areas. Medical students can also be offered rural, bonded scholarships of up to \$20 000 tax free annually, to study for their degree. In return, students agree to work in a rural location for six years once they have graduated (Birrell, 2001; Boffa, 2002; Wearne & Wakerman, 2004). At this stage, it is too early to evaluate the success of this initiative.

---

<sup>8</sup> See <http://www.ruralhealth.gov.au/workers/rrp.htm>

<sup>9</sup> See <http://www.ruralhealth.gov.au/studying/index.htm>

The Practice Incentive Program (PIP) is a \$241million program established in 1998 which aims to recognise general practices that are either accredited to the RACGP standard for general practices or are working towards accreditation to improve quality care for their patients. Incentives are generally paid to the general practice and target specific areas such as information management, information technology, after hours care, teaching, and employing practice nurses. The PIP program encourages quality of patient care rather than the quantity of patients seen by the GP by compensating GPs who carry out long consultations or do after-hours work (Australian Government Department of Health and Ageing, 2005: 78-80).<sup>10</sup> For those practices involved in the program, other financial incentives flow on. The 2001-2002 *Federal Budget Nursing in General Practice Initiative* allocated a further \$104.3 million over four years to encourage general practices in areas of high workforce pressure to employ more nurses.<sup>11</sup>

The Divisions of General Practice Program<sup>12</sup> was established in urban and rural locations throughout Australia and was funded by the Commonwealth government (see map 1). Divisions of general practice were set up in 1992 to forge better links between GPs and other health agencies. Australian Divisions of General Practice (ADGP) are a key partner with the AMA, RACGP and RDAA (Australian Government Department of Health and Ageing, 2005). Their aim is to improve patient health outcomes by encouraging cooperation between GPs and other health professionals and offering opportunities and support for them to meet and work together. Divisions of general practice also offer services where they represent GPs in the hospital and community. In these contexts, they negotiate GP access to hospitals, provide continuing medical education for GPs, organise peer review and quality assurance in patient care, facilitate undergraduate teaching and vocational training, and participate in primary care

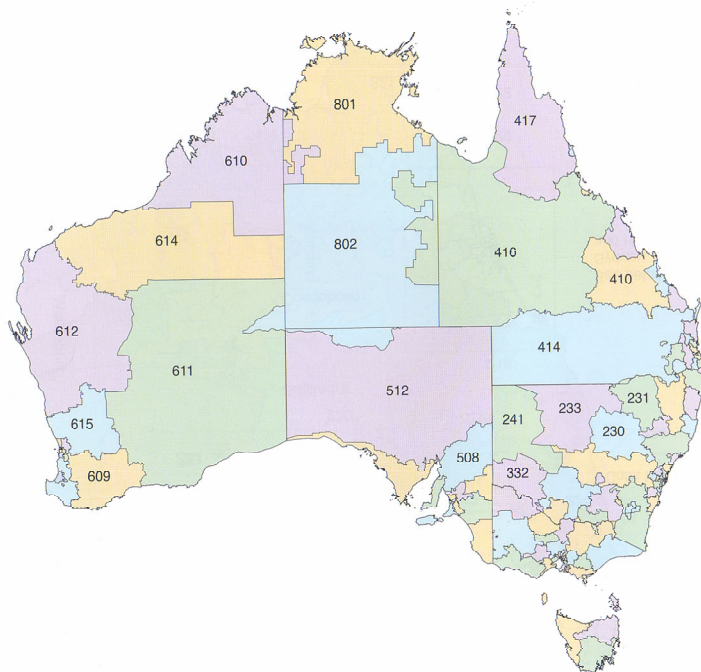
---

<sup>10</sup> For further information, see:

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-pipepcreview.htm>

<sup>11</sup> See <http://www.health.gov.au/pcd/programs/nursing/budget.htm>

<sup>12</sup> See <http://www.ruralhealth.gov.au/workers/dgp.htm>



**Map 1: Australian Divisions of General Practice.**

Source: Australian Government Department of Health and Ageing, 2005, *General Practice in Australia, 2004*, p.613

research, health promotion and education (NHS 1992 cited in General Practice Strategic Policy Development Unit, 2000: 11).

It is against this backdrop of government support that Australian trained doctors have been actively recruited to work in rural locations. Such generous incentives are not offered to other health professionals, notwithstanding their significant role in rural health care. The ongoing difficulty in attracting Australian trained medical practitioners is met by providing more incentives for them to work in areas of unmet need. If doctors agree to work in these areas, they are now eligible to apply for relocation grants that can amount to \$20 000 for a single GP and \$30 000 for a married GP couple (Western Australian Centre for Remote and Rural Medicine, 2003).

Yet with such lures, why are Australian trained doctors so reluctant to leave the cities and work in rural areas of unmet need? One response to this question is seen in the decline of rural populations raising questions of viability in establishing a private general practice. Consequently, many communities are recruiting salaried or overseas trained doctors (Jones, Humphreys, & Adena,

2004). According to the findings of the *National Rural General Practice Study* GPs are increasingly unlikely to want to work under conditions traditionally associated with general practice in rural locations such as long working hours, unacceptable on-call arrangements and lack of locum relief (Strasser et al., 1997). These findings suggest that expectations for rural GPs to have an heroic commitment to meet the demands of their work are changing. Nonetheless, GPs seem reluctant to move outside the city with its lifestyle, choices in education for their children within a reasonable distance from home, acceptable on-call arrangements, job opportunities for spouses, professional training, housing, and cultural activities (Holub & Williams, 1996; Kamien, 1987). Boffa (2002) suggests that GPs prefer to work in more desirable urban locations with better working conditions and income protection, even though their choice often creates a surplus of GPs relative to the needs of the community (Boffa, 2002: 301). According to Kamien (1987: 41) this decision would make sense given that most doctors are drawn 'mainly from middle or upper middle class ... [where] it would be expected that, when in the country, many would miss the trappings of middle class society'. Add to this the limited number of medical graduates brought up in rural areas and an overall picture emerges of the distribution of GPs between urban and rural locations.

As a result, further incentives are offered to encourage GPs to move to rural areas. The Australian General Practice Training Program (formerly the RACGP Training Program) offers a three year training course with two pathways, rural and general. It consists of a hospital year, a six month basic term followed by a six months advanced term and a year of experience as a GP. Registrars can then choose a further year in advanced rural skills training. Those who opt for the rural pathway are offered financial incentives by the RACGP if they agree to do 18 months of their training in rural locations. Places on the Australian General Practice Training Program (formerly the RACGP Training Program) have been increased from 400 in 1997 to 600 in 2004. Competition for entry onto the program is fierce, yet, despite the inducements, many rural registrars return to urban general practice when they have completed their training (Australian Government Department of Health and Ageing, 2005)

Studies often imply that GPs view rural practice ambivalently in that the factors that lead them to work in a rural location also inform their decision to leave. In other words, GPs may be attracted by the diversity of work practice that rural general practice offers, including the opportunity to provide continuity of care to the community. Many GPs also enjoy a sense of independence and autonomy working in this setting (Strasser et al., 1997). However, the flip side of the coin is often overwork, unacceptable after-hours on-call arrangements, inadequate locum relief, professional isolation, limited access to continuing medical education in some areas and the inability to do procedural work when hospitals downsize or close. Add to this a lack of childcare facilities, few opportunities for spousal employment and subsequent deskilling of spouses, family pressures, and relationship breakdown (Kamien, 1987; Maher, 2001; Strasser et al., 1997; Wainer, 2002) and the picture painted is less appealing. Recognising the challenges faced by rural GPs and their families is important. Isolation and distance from family and friends and professional support can make settling in difficult (Humphreys & Rolley, 1998; Kamien, 1987, 1998; MacIsaac et al., 2000; Snadden, 1993). However this is the case for many workers and professionals leaving their families and friends to set up a new life in rural Australia, though most have to survive without the generous resources, incentives and support offered to the medical profession and their families.

In contrast to a gloomy depiction of life outside the cities, there are those who grew up in rural Australia, love the rural lifestyle and want to return. Students with rural backgrounds are four times more likely to work in rural medicine than those who grew up in the metropolitan area (Kamien, 1987: 74). In the United States, the most important predictor of a doctor choosing rural practice was having a rural background (Rabinowitz et al., 1999). Despite this finding, there are GPs and their spouses who have always lived in the city but who choose to live and work in a rural location. They embrace the rural lifestyle, including opportunities to farm. They enjoy the autonomy and skills rural practice offers in terms of clinical independence and procedural work (MacIsaac et al., 2000). Many rural GPs and their families are happy to be part of the local community and often develop a loyalty to those living in the area, a factor that contributes significantly to their decision to stay (Green, 1993; Hays, Wynd,

Veitch, & Crossland, 2003; Lippert & Tolhurst, 2001). These responses were certainly evident in my own research which will be discussed in later chapters.

While difficulties persist in attracting Australian GPs to work in rural locations, particularly in locations designated as areas of unmet need, solutions continue to be sought within a medico-centric paradigm. The Commonwealth Department of Health and Ageing (DHA) and the Department of Health in Western Australia determine districts of workforce shortage within the RRMA classification (See Table 1). Vacancies in these locations are initially advertised to Australian trained GPs. If positions remain unfilled, OTDs are increasingly being called upon to bridge the gap in medical services in these areas (Birrell & Hawthorne, 2004; Donovan, 2003). While this solution offers a stop-gap in medical service provision, it can be problematic. In isolated smaller rural locations, professional or cultural support for incoming OTDs is often limited. Miles et al. (2004) argue that these issues need to be resolved if recruitment and retention is to be successful. Many of the locations in which rural OTDs initially work are designated as areas in need of medical services that are often located inland and may be isolated. This picture reflects the diversity of rural general practice and the challenges posed by some settings, important issues when considering the adjustment to a new way of life not just for OTDs but also their spouses and families, particularly those from different cultural and linguistic backgrounds.

Since 2000, the Commonwealth government has committed millions of dollars to meet the needs of rural medical practitioners which has included encouraging the Divisions of General Practice to support OTDs working in special workforce programs (Australian Government Department of Health and Ageing, 2003). According to Birrell and Hawthorne (2004), OTDs will be recruited over the next few years as the mainstay of the Commonwealth government's Medicare Plus program to provide 1500 full-time equivalent (FTE) positions in areas of need. As a result, active recruitment of OTDs was, and still is, considered necessary to provide medical services in rural locations, at least until sufficient local graduates fill the places (Australian Medical Workforce Advisory Committee, 1999; Donovan, 2003).

However, increasing the number of local graduates to fill the places offers no guarantee that the situation will improve in areas of unmet need, given the reluctance of many Australian medical graduates to work outside cities. Indeed, concerted efforts to resolve the problem by allocating Medicare provider numbers based on areas of unmet need in order to provide a more equitable distribution of Australian trained medical graduates (Hamilton, 2001) have been thwarted by the medical profession. The AMA cites legal advice that refutes the geographical distribution of Medicare provider numbers. It claims this would coerce doctors to work in these areas which contravenes the “civil conscription” clause in the Australian Constitution (Australian Medical Association, 2001b). AMA resistance and State support of a medico-centric approach to rural health care suggest that employing OTDs to fill positions unwanted by Australian medical graduates will prevail for a while yet.

Claims of an over-supply of medical practitioners in Australia, supported by figures showing that the medical workforce had doubled from 1976-1996 even though the Australian population grew by only 30 per cent (Australian Medical Workforce Advisory Committee & Australian Institute of Health and Welfare, 1998), were resoundingly rejected by the AMA. The AMA argued that there was an undersupply of medical practitioners in urban as well as rural and outer-suburban Australia. Results from a survey commissioned by the AMA of 7000 GPs showed that part of the reason for this under-supply was inadequate remuneration and the need to train more GPs in the future to fill this gap (Phelps, 2002). This argument implies that, with the right financial incentives, GPs will want to work in areas of unmet need when evidence shows this is not the case. Yet any moves by governments towards a better distribution of the medical workforce have generally been met with resistance such that positions in rural areas remain unfilled. Any kind of diffusion of rural GP services with those of other health professionals to provide a more collaborative and innovative approach to rural health care has also been resisted by the AMA (Australian Medical Association, 1994).

However, in order to meet the health needs of rural communities, the Western Australian *Country Health Services Review* demonstrates the need for flexibility in rural health service delivery rather than reinforcing a medico-centric

focus. The report recognises rural diversity where a one size fits all approach is not always appropriate to meet rural health care needs (Department of Health, 2003: 22). Whilst the importance of the medical profession in rural health service delivery is recognised in the report, it is interesting to note that the future of sustainable, private, rural medical practice was seen as doubtful despite significant investments from local and Commonwealth governments in incentives to attract and retain doctors (p.25). Nevertheless, in response to GPs' demands for better conditions in rural locations (see Strasser et al., 1997), the Commonwealth government continues to support the need to offer more incentives to attract and encourage GPs to remain working in a rural area. Despite this, findings from a recent study indicate that there has been no change in the maldistribution of Australian trained medical practitioners with most rural communities relying on doctors trained overseas to provide medical services (KPMG Consulting cited in Boffa, 2002, p. 301). Unable to recruit locally trained doctors, incentives are then offered to attract and retain OTDs.

### ***Incentives for overseas trained doctors***

Fearing a political backlash from the growing crisis of inadequate medical services in rural areas, exacerbated by the difficulty in attracting and retaining Australian medical graduates, the Commonwealth government facilitated the recruitment of doctors trained overseas into hospitals in large rural centres and rural general practices. Visas granted to overseas trained medical practitioners increased from 875 in 1995-1996 to 1780 in 2000-2001 (Birrell, 2001). These doctors were recruited by state and local governments and private providers to work on short or medium-term contracts (Hawthorne & Birrell, 2002). The Commonwealth government had established pre-requisites for accreditation to practise medicine whereby OTDs entering Australia, except those from New Zealand, had to pass exams set by the Australian Medical Council (AMC). This required that doctors from non English speaking backgrounds complete an occupational English test in addition to passing the AMC medical knowledge multiple choice test and AMC clinical examinations (Birrell, 1997; Hawthorne & Birrell, 2002).

The Australian Medical Workforce Advisory Committee Working Party advocated the ongoing use of OTDs on temporary resident visas (TRVs), a policy which looks set to continue indefinitely. It argued that this temporary medical workforce could fill essential gaps in services in those areas unable to attract Australian trained doctors (Australian Medical Workforce Advisory Committee, 1999). To meet the growing rural crisis, requirements to pass AMC exams were subsequently waived or removed by state medical boards. This move led to many OTDs on permanent resident visas (PRVs) feeling frustrated that they were being overlooked in favour of doctors on TRVs. To be eligible for a TRV, OTDs were required to work for up to four years in areas of need designated by the state or territory in which they were living. The AMC was not required to assess their medical qualifications (Birrell, 1997; Birrell & Hawthorne, 2004). Numbers of TRVs issued to OTDs increased from 664 in 1993-4 to 2496 in 2003-4 (Birrell & Hawthorne, 2004). OTDs on PRVs eventually were eligible for conditional registration if they agreed to practise in designated areas of unmet need where vacancies had not been filled by Australian trained doctors (Hawthorne & Birrell, 2002).

By the late 1990s, over 69 per cent of OTDs came from the United Kingdom and 10.3 per cent of doctors working in areas of unmet need were from South Africa (Australian Medical Workforce Advisory Committee, 1999). In 2001-2002, the majority of doctors who graduated overseas and who billed Medicare for their services had trained in Asia followed by the United Kingdom (Australian Government Department of Health and Ageing, 2005: 110). The recruitment of doctors trained overseas, who are on medium or short-term contracts in order to boost the numbers of GPs providing rural medical services, is still seen as an interim measure. Current policies aiming to increase the number of Australian graduates working in areas of need expect results by 2010. By then, it is assumed that the number of GP trainees will have increased and the number of doctors trained overseas will fall correspondingly. The present aim is to have a minimum intake of 450 medical practitioners onto the GP training program and to accept an annual intake of 200 doctors trained overseas (Australian Medical Workforce Advisory Committee, 2000).

## ***Western Australia***

The Overseas Trained Doctors' Program in Western Australia (WA) began in October 1999 and is currently administered by a Rural Workforce Agency, the Western Australian Centre for Remote and Rural Medicine (WACRRM) in Perth. WACRRM is the only body eligible to admit doctors trained overseas onto the program in WA, which is the first of its kind in Australia (Donovan, 2003; Roach, 2003). This is a collaborative scheme requiring that OTDs work in a specified area of unmet need for five years under conditional registration with the state medical board. During this time doctors are required to pass an exam set by the Royal Australian College of General Practitioners. Once they have met these criteria, they are eligible to apply for an unrestricted Medicare provider number allowing them to practise anywhere in Australia (Department of Health, 2003; Donovan, 2003). These requirements have since been updated. A recent policy position statement by ARRWAG on OTDs recommends that in order to attract OTDs to work in very isolated areas, the Five Year OTD Scheme can be modified. Each year a doctor works in an isolated location counts for two years in a rural location. If an OTD remained in a isolated area for two and a half years, he/she would be eligible to meet the requirement of the five year scheme and be allocated an unrestricted Medicare provider number (Australian Rural and Remote Workforce Agencies Group, 2004).

On arrival in Western Australia, OTDs undergo a week long orientation program organised by WACRRM while they are completing medical registration procedures. In 2002, of the 68 OTDs entered onto the WACRRM data base who were working in rural Western Australia, 26 came from South Africa, 11 from the UK and nine from Nigeria (Roach, 2003). In the last two years, about 50 OTDs (10 per cent of the WA rural GP workforce) were practising under the Five Year Rural Recruitment Scheme (Department of Health, 2003). Before being accepted onto this scheme, OTDs are generally required to take up a locum position for six months where they can be assessed for their suitability for rural practice. This period also gives doctors and their families the opportunity to work out whether living and working in rural WA suits them. Sixty per cent of the locum work-force Australia-wide comprises OTDs on TRVs who have above

average representation in Western Australia compared to other Australian states and territories (Donovan, 2003).

Incentives to attract OTDs to the program are varied. At a local government level, rural shire councils assist by often providing free or subsidised housing, a surgery and vehicle as well as ensuring doctors and their families are welcomed and supported by the local community (Department of Health, 2003). At a professional level, assistance with travel and orientation costs for the doctor, provision of workshops and examination and administration costs are also provided (Donovan, 2003).

### ***Maintaining medical care in rural locations***

Recruiting OTDs to work in designated areas of need that are unable to attract their Australian trained colleagues is one solution to the rural health problem. The belief that rural towns need a doctor has often been reinforced by health policy and accepted as the norm by rural communities. At another level, the diffuse nature of power in social relationships is evident when hegemonic notions of health care are reproduced in decisions made by local communities to resolve the rural health problem by providing and maintaining medical services (see Turner, 1997). Kamien (1987: 30) suggests that people living in rural locations have 'high expectations of medical services, often greater than is possible to provide'. On the other hand, it could also be argued that many doctors have high expectations of rural communities to provide for their needs. Much time, effort and financial resources have been allocated by rural shire councils to offer services to GPs such as finding locums, providing furnished housing and often a car, and navigating the maze of bureaucratic requirements in order to recruit OTDs. However, there is a sense of community frustration when, with that level of outlay and effort, doctors leave after a short period (Mills, 1997). This raises the question of how realistic are the expectations of both the local community and the GP about the process of providing services. In other words, how, and by whom and for how long should medical services be provided? Should a distinction be clearly drawn between health services and medical services?

Rather than expand the rural health discourse beyond a medico-centric focus, rural shire councils have generally worked within that paradigm. Some councils have contracted the services of private corporations who guarantee to provide the community with a GP and organise his/her recruitment for an annual fee negotiated with the council. While the rural shire council often provides accommodation, a vehicle and a furnished surgery, the corporate organisation recruiting GPs may assist GPs to meet bureaucratic requirements, manage the practice and sometimes provide information technology (IT) equipment. The private GP will then pay a percentage of his/her income to the corporate organisation for practice management. The effects of this arrangement at the level of social practice will be addressed in subsequent chapters. While rural communities hope that such incentives will assure continuity of medical services, the question raised is whether such incentives contribute to the decision of GPs and their families to stay in rural locations?

## **Retention**

Retaining GPs and their families in rural locations is often portrayed as an either/or situation: either you stay or you leave (Cutchin, 1997). Cutchin (1997: 39) claims that many studies maintain a problem/solution focus and offer a list of factors that either lead to, or prevent, retention as if it were a 'nervous system response to a particular stimulation threshold'. This approach implies that the 'right' incentives will lead to the 'right' outcomes even though this has not been the case so far in terms of providing adequate rural GP services. Nonetheless, ARRWAG recently recommended even more financial incentives to attract doctors to work in rural areas over and above those they already receive (Australian Rural and Remote Workforce Agencies Group, 2003-2004). The linear approach of such studies does not address the complexities of the issue that are evident when seeking to understand 'retention' in a wider social context. Adopting a broad approach also allows a more nuanced exploration of the relationship between structure and social practice.

Maintaining the focus on attracting GPs to work in areas of need by increasing the financial incentives reproduces hegemonic ideas about rural health service delivery that effectively side-line creative solutions to the problem

outside that paradigm. The experience and skills of other health professions are subordinated to those of the medical profession and a concerted effort to address other determinants of rural health in a way that may improve health outcomes and reflect diversity between rural communities are subjugated in favour of a 'one-size-fits-all' approach.

A medico-centric focus can, by definition, work against collaborating with other health professionals in a non-hierarchical setting. Instead it can and does create divisions between GPs and other health professionals and between GPs and the local community (Joyce et al., 2004; Keleher, 1999; Mills, 1997). Indeed, the financial and social costs incurred by many rural communities of recruiting GPs led one rural town to plead with new arrivals to 'become part of the community to be accepted and not just use it as a means of income' (Mills, 1997: 196). Interestingly, studies on retention show that GPs who are involved in the community are more likely to stay.

In Australia, Humphreys and Rolley (1998) stress the importance of GPs feeling part of the community. Kamien (1987) found that over 50 per cent of rural doctors in his study enjoyed their environment and were reported to be involved in the community. Hays et al. (2003) conducted a follow-up study on their original research where they re-interviewed a group of rural GPs after 10 years to discover why they were still in country practice. Of the 23 in the original cohort, 72 per cent continued in rural practice citing strong community links as one of the reasons they stayed. Over time, GPs' integration into the social fabric of the community made leaving a less attractive option. Those who were not integrated into the community tended to leave. In the United States, research shows that doctors who identify with, and feel part of, the community are more likely to develop a sense of loyalty to the location (Cutchin, 1997). Cutchin (1997) expands on this view by suggesting that new meanings emerge from those who have integrated into the community that suggest that place and community are reasons to remain in a particular location. Professional satisfaction is another reason.

Kamien (1987) discovered over 80 per cent of rural GPs in his early study found their work challenging and fulfilling. Over 90 per cent were satisfied with

what they were doing and appreciated being able to use ‘a wide range of skills and to provide a continuity of care to people they knew and whose family dynamics they often understood’ (p.41). Kamien’s (1998) later study examining the outcomes of GPs in his 1987 research, found that most participants were still concerned about overwork due to long hours with no locum relief, lack of medical back-up in emergencies, the downsizing of rural hospitals, insufficient income and limited access to continuing medical education. Currently, GPs on average work up to 26 per cent longer in very isolated rural locations than those in major cities. Fourteen per cent of those in major cities work over 60 hours a week compared to 27-40 per cent in isolated rural areas (Phillips, 2005: 21). Despite this, of those who had planned to leave in Kamien’s (1998) study, 49 per cent had stayed, and of those who had planned to stay, 24 per cent had left.

However, there seems to be a contradiction in factors affecting GPs’ decisions: professional issues drive some doctors to leave at the same time as encouraging others to stay. This highlights the diversity inherent in GPs’ expectations and experiences of rural general practice. Recent findings from a review of national and international published reports suggest that rural background is a significant factor in doctors remaining in rural practice (Laven & Wilkinson, 2003). However, a study from the US found that, while rural background was an important predictor in recruitment to rural practice, retention was more influenced by professional issues such as income and workload (Rabinowitz et al., 1999). GPs’ responses to structural requirements suggest that increased bureaucratic intervention in professional life was another factor driving GPs to seriously consider leaving general practice altogether (Kamien, 1998). Findings from the NRGp study found that many rural GPs were angry at the increasing government encroachment into clinical practice (Wainer, 2002). In Kamien’s (1998) follow-up study to his 1987 research, over 50 per cent of GPs who had left rural practice had been unable to solve the problems they had and, understandably, felt despondent. However, those who stayed had resolved most of their concerns including overwork, forced deskilling and conflict with other health care professionals and they acknowledged the importance of their work in the community. This suggests a degree of ownership of responsibility to resolve the issue rather than projecting the problem onto others to solve.

Nevertheless, in order to encourage GPs to work in rural areas governments are attempting to resolve the problem by offering GPs a plethora of incentives to stay. However, it seems that many practitioners remain discontented in rural general practice with calls that not enough is being done to improve their plight. GPs continue to berate government for their demanding workloads, lack of locum relief and lack of access to services, not feeling valued and supported for the work they do, and inadequate educational opportunities for their children (Strasser et al., 1997; Wainer, 2002). These concerns reveal the tension when GPs resist structural expectations by demanding changes to work practices. Notwithstanding a variety of incentives to make the life and workloads of GPs more manageable and enjoyable, heavy workloads persist and the physical and mental health of many GPs suffers. There is pervasive feeling of negativity about rural general practice underpinning the experiences of many rural GPs (Wainer, 2002). Stress, depression, relationship breakdown, alcoholism and high suicide rates amongst GPs relative to other professions are not uncommon and compromise quality in work performance (Winefield, 2003). Medical culture also acts as a constraining factor on doctors acknowledging and discussing their problems given the stigma attached to doctors seeking help (Frost, 2002). Not coping is seen as unacceptable and the doctor in the role of patient is considered an anomaly. As a result, doctors often minimise, deny and are reluctant to report any symptoms, conforming to the view that 'patients get ill, doctors don't' (McKevitt & Morgan, 1997: 648). Other research has questioned whether the stress of work is counterbalanced by their professional autonomy and the prestige and status they enjoy in the community where, despite morbidity, their job satisfaction is generally high (Winefield, 2003).

However, at the present time, many rural GPs are feeling their autonomy in their work setting is being eroded as rural general practice undergoes a transition in the light of structural changes leading to a sense of uncertainty and frustration surfacing among the rural medical workforce (Strasser et al., 1997). Added to this, Kamien's (1987) observation that rural centres may not meet the social and cultural needs of middle and upper-middle class GPs feeds into the notion that rural locations are deficient in meeting their needs as well as those of their families. Even though most rural GPs are married or in committed

relationships, most studies on recruitment and retention centre on the needs of the GP with less focus being placed on the contribution and needs of their spouse.

Research into the spouse's role, expectations and experiences is limited. However, various studies have addressed the importance of meeting spouses' occupational, educational and training needs in rural areas (Nichols, 1997; Wise et al., 1996) and the effects of their loss of identity as separate from that of 'doctor's wife' (sic) (Lippert, 1991). Kamien (1998) found the role played by spouses in the decision to stay or leave rural general practice was significant given that the 'the success and retention of a doctor depends to a large extent on the adaptability of the spouse' (Kamien, 1987: iv).

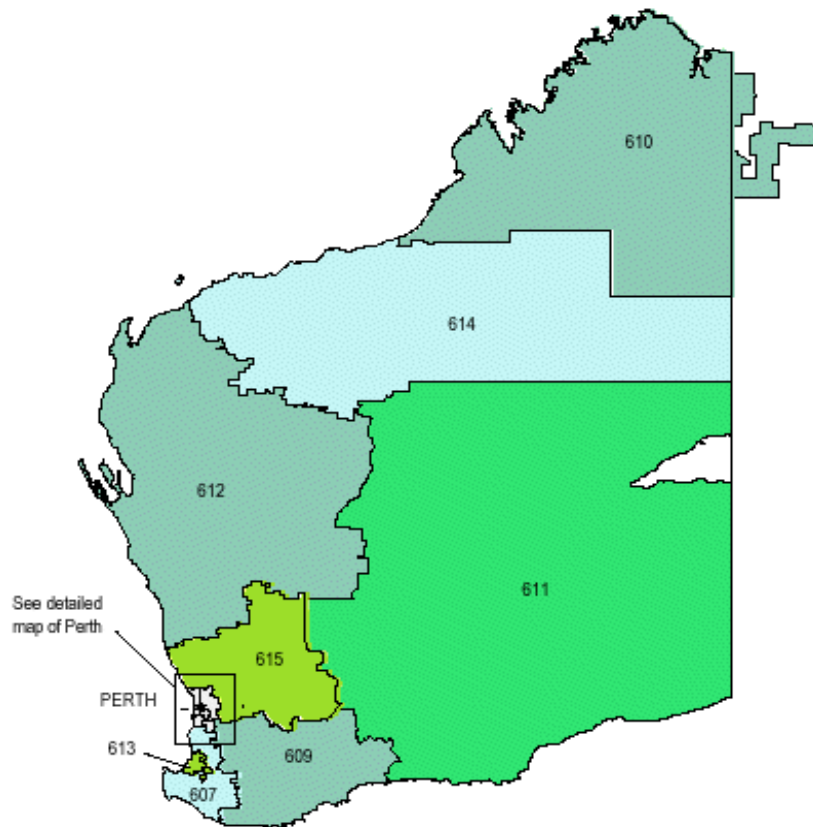
The image of the role of rural GPs' spouses, particularly the female spouses, is seen as supporting the work of their partners, often subjugating their own professional aspirations in the process (see Sevier, 1990; Wise et al., 1996). Repeated studies have overlooked the significance of gender analysis as a way to understand broader issues driving the recruitment and retention of rural GPs and their spouses. This thesis will pick up on changes to rural general practice brought about by gender relations. Not including spouses in the recruitment and retention process undermines their importance and reinforces their subordinate role. Chapter Eight directly addresses their expectations and experiences and the extent to which they are informed by structural issues. It examines the effect of hegemonic expectations of gender relations in social practice where perceptions of their role as 'doctor's spouse' are explored in relation to recruiting and retaining rural GPs. But first, I draw on the ethnographic tradition to contextualise the research by taking the reader on a journey through the region in the next chapter. I describe the locations in which GPs and their spouses live and work that provide a backdrop to their expectations and experiences and reveal the diversity of country general practice.

## **CHAPTER 3**

### **Country general practice: the place and the people**

The setting for this research is a richly diverse area covering 87,000 square kilometres in the southern part of Western Australia. This region is designated as the Great Southern Division of General Practice (GSDGP), represented as Area 609 on Map 2. The Division stretches from the coastal towns of Walpole in the southwest to Ravensthorpe in the southeast, north to Kondinin via Lake King and Lake Grace then west to Brookton (see Map 3). Towns are situated within specific rural shires within that circumference that are managed by discrete shire councils that constitute part of the organisational structure of local government (see Map 4). Towns covered by the GSDGP include the large rural centre of Albany, the service towns of Narrogin and Katanning, the vineyards and tourist centres of Mount Barker and Denmark, all medium rural centres with sufficient populations to support several GPs. The smaller, and often more isolated rural shires with populations generally well under 4000 offer the services of solo GPs. General practices are situated within specific shires where the surgery is located in the main town, often with branch clinics offered in smaller towns within the shire.

The landscape of the area covered by the GSDGP is diverse and ranges from the majestic beauty of eucalypt forests in the southwest, including the Valley of the Giants where tingle trees in the Walpole Nornalup National Park tower above the landscape, to Ravensthorpe in the east, close to the coast and currently the site for the proposed BHP Billiton \$950 million nickel mining operation. The flat, salt-lake plains dot the cleared, pastoral landscape of the more remote northeast of the region around Lake King and Lake Grace. This area stretches for hundreds of kilometres in each direction to be met in the south by sandy beaches extending along the coastline. The regional centre of the Great Southern area of Western Australia is Albany, an attractive, thriving coastal town of over 30 000 people. It offers numerous services for residents and tourists, well- maintained buildings that reflect its history as the first white settlement in



## Map 2: Western Australian Divisions of General Practice

Source: Retrieved January 2, 2005, from Western Australian Divisions of General Practice website: <http://www.gp.org.au/wa.html>

Western Australia, a natural deep water harbour and beaches with sand the colour of snow. The town has a genteel atmosphere, is home to many retirees and draws large numbers of tourists to the area not least because of its mild climate and natural beauty.

Descriptions of the various locations help to convey notions of diversity, distance and isolation that pervade the lives of those living and working in rural areas, particularly when accessing basic services such as health care, education and banking. I use my own observations and impressions to help the reader become acquainted with the land and its people as I visit and spend varying amounts of time in all the shires that offer the services of a GP. When meeting residents, I engage in informal discussions and explain the nature of my project and seek to understand their ideas and experiences of rural medical services. I also make a point of contacting those who are more closely involved in

implementing medical services such as individuals working in local government or state funded hospital and community health care. To substantiate my



**Map 3: The Great Southern region of Western Australia: Localities within the Great Southern Division of General Practice.**

Source: Retrieved January 10, 2005, from The Great Southern Division of General Practice website: <http://www.gsdgp.com.au/GSDGP/about.aspx>



**Map 4: Shires in Southwest and Great Southern Region of Western Australia**

Source: Retrieved January 3, 2005, from the Shire of Lake Grace website: <http://www.lakegrace.wa.gov.au/>

observations and impressions, and those of others, and to offer a more nuanced understanding of the landscape, history and socio-economic environment, I draw on archival material from libraries, local shire council offices, hospitals and tourist offices as well as census material from the Australian Bureau of Statistics. I also seek to understand the effects of socio-economic changes on rural restructuring and development and on medical service delivery by listening to local community responses. I visit government and other websites for added

information and resources relating to the various locations in the region and I make use of personal communication to clarify or elaborate on various issues.

## **Landscape**

I began my fieldwork journey by spending two months living in Albany which I used as a base to visit Denmark and Mount Barker, locations in reasonably close proximity. Albany is the administrative centre of the region covered by the GSDGP and is situated on the coast 405 kilometres southeast of Perth, adjacent to King George Sound. The English explorer and navigator, George Vancouver, named this expanse of water after King George III (Johnson, 1989). It is a natural, deep water harbour which was originally the main port in Western Australia before the construction and opening of the port at Fremantle, just south of Perth in 1897.<sup>13</sup> The mouth of the Sound faces eastward into the Southern Ocean towards the Great Australian Bight. Adjoining the Sound are two harbours, Oyster Harbour to the north into which flow the Kalgan and King Rivers and, to the west, Princess Royal Harbour flanked in the north by Point King and in the south by Point Possession, all areas of great natural beauty. Princess Royal Harbour is an expanse of water protected from the high seas and gale force winds. On the northern side of the harbour are Mount Melville and Mount Clarence. Albany rests on the slope between these two granite outcrops and the sea. Granite and limestone cliffs tower above white sandy beaches on the coastline around Albany and add to the ‘vistas of ocean and cliffs, harbours and hills and surf [that] make King George Sound one of the most beautiful and dramatic spots on the Australian coastline’ (Garden, 1977: 3). Southern right whales can be viewed from the shore as they migrate between July and September and sperm, humpback and the rare and endangered blue whales also swim through the waters off the southern Western Australian shores (Great Southern Development Commission, 2003). The Bibbulmun Track, named after Indigenous inhabitants of the area, is another feature of the region. It is a 900 kilometre walk from Perth through a variety of landscapes to Albany. It was

---

<sup>13</sup> Information obtained from: <http://www.freport.wa.gov.au/Educaton/history/1827.aspx>

officially opened in 1979 and was designed to encourage urban people to 'go bush'.<sup>14</sup>

A holiday atmosphere prevails in Albany, even in winter, that helps to create a sense of vibrancy. People of all ages congregate in York Street, the main road in the town, as they attend to their business, stop to chat, shop, browse, take time out in one of the several, good coffee shops that reflect a burgeoning café culture in the town, or visit one of the pubs. I walk down the street flanked on either side by stately, federation buildings juxtaposed with modern retail outlets and, looking straight ahead, I can see King George Sound which provides a dramatic backdrop to the town. The hills around the city centre offer extensive coastal views for those fortunate enough to be able to afford to live there where an air of gentility prevails. Others can enjoy equally impressive views from driving or walking through Mount Melville or Mount Clarence.

The population of Albany is growing and has reached over 30 000. People are attracted to its mild climate, business opportunities, relaxed lifestyle, schools, health care services, attractive coastal scenery, bush walks, history and proximity to vineyards as well as the many organisations, clubs and sporting activities available for those wanting to be more actively involved in community life. There is a range of health and medical services including 31 GPs who work out of nine general practices. Numerous sporting and recreational facilities and an active arts community point to a rural centre that is thriving rather than declining. Tourists can choose from a range of holiday accommodation from the more luxurious hotels and self-catering boutique chalets to bed and breakfast accommodation and self-contained units to caravan parks and backpacker hostels.

Fifty one kilometres west of Albany and 400 kilometres south of Perth is the town of Denmark, which, according to information from the local tourist office, was named after the first naval physician from 1814-1835, Dr Alexander Denmark. I visited Denmark several times from my base in Albany to familiarise myself with the area, to interview GPs and their spouses and to meet local

---

<sup>14</sup> For extended history of its construction see <http://www.bibbulmuntrack.org.au/history.asp>

residents. It is another place of great natural beauty, built along the Denmark River and around Mount Shadforth and the Wilson Inlet. The shire is a popular tourist destination and offers a variety of scenery from a rugged coastline to forested areas, including the Walpole Nornalup National Park, to vineyards. The shire covers an area of 1842 square kilometres and has a population of about 5600 and medical services are provided by eight GPs from two separate practices. The main street of the town outside the main tourist season conveys an air of sleepiness with few people congregating and several shops empty until the next holiday season. Denmark is a popular place for those wanting to live an alternative lifestyle (See Table 3 for a synopsis of information on the GSDGP).

**Table 3 Snapshot of the shires in the GSDGP**

<b>Rural city (C) town(T) shire(S)</b>	<b>Area sq.kms</b>	<b>Distance ex Perth (kms)</b>	<b>Distance ex Albany (kms)</b>	<b>Population (ABS 2003 estimates)*</b>	<b>Industry</b>	<b>GPs</b>
Albany (C)	4804	405	0	31 550	Regional cultural and service centre, tourism.	31
Jerramungup (S)	6451	454	176	1199	Fishing, fish processing, agriculture mainly broad acre farming but also grain cropping, sheep, timber plantations, vineyards and seed potato farms. Tourism around Bremer Bay.	1
Ravensthorpe (S)	13 553	532	293	1436	Broad acre farming, meat, wool, nickel mining, tourism.	1
Lake Grace (S)	9245	347	261	1558	Farming: wheat, canola, oats, barley, lupins and various legumes. Also sheep for wool and meat; yabbies (freshwater crayfish), wine grapes and oil mallees.	1
Kondinin (S)	7340	279	360	993	Farming wheat and coarse grain; sheep and wool and tourism (Wave Rock).	1
Boddington (S)	n/a	128	318	1421	Farming; coarse grain producing area and sheep. bauxite mining, small farming eg marron, flora culture, horticulture, ostriches, alpacas.	1
Pingelly (S)	1294	158	320	1179	Farming: mixed grain, sheep, cattle and pigs. Also yabbies, market gardens, emus and ostrich farming and wine grapes.	1
Narrogin (S)	n/a	192	281	765	Farming mixed grain and sheep.	
Narrogin (T)	n/a	192	281	4671	Service town.	7
Wagin (S)	1950	229	222	1836	Farming mainly mixed grain and sheep. .	1
Katanning (S)	1523	280	170	4433	Service town; pastoral, mixed grain with high production of cereal grain; sheep, halal meat works.	4
Gnowangerup (S)	5000	356	165	1495	Farming: mixed grain including wheat and canola as well as peas and faba beans, livestock, tourism	1
Kojonup (S)	n/a	256	154	2228	Farming: mixed grain and sheep.	1
Plantagenet (Mt Barker) (S)	4800	360	47	4500	Viticulture, horticulture and agro-forestry. Farming: cereal, oil and legume crops, tourism, livestock, orchards, commercial tree farms.	4
Denmark (S)	1842	400	51	5051	Tourism, viticulture, dairy farming.	8

Source: Information obtained from Regional Population Growth, Australia and New Zealand, 2002–03 (ABS cat. no. 3218.0) and Population by Age and Sex, Western Australia (ABS cat. no. 3235.5.55.001) and rural shire council websites.

Forty seven kilometres north of Albany is Mount Barker in the Shire of Plantagenet which I also visited several times while being based in Albany. It is located in an agricultural region with a population of 4500 and four GPs offer

their services from one general practice located in Mount Barker. The town gives the impression more of a service centre for farmers rather than one that offers much for the tourist. However, this area is renowned for its world class wines and the vineyards around Mount Barker are a significant drawcard to attract visitors and help boost the local economy.

Following my stay in Albany, I drove to Katanning where I stayed for a few weeks. I used it as a base to meet local GPs, spouses and community residents and visit neighbouring towns such as Gnowangerup. Katanning is located 170 kilometres north of Albany and 280 kilometres southeast of Perth and the shire covers an area of 1523 square kilometres. It is the largest stock selling centre in the Western Australia and is renowned for its cereal grains ever since the first flour mill was built in the town in 1891. It has a population of about 4400 and four GPs, all of whom trained overseas, provide medical services. Walking down the main street I was struck by a sense that the town was in decline. Vacant shop windows and peeling paint on shop fronts gave the impression of the place being in a state of disrepair. In the main centre there was one coffee shop tucked away in a dingy mall where several adjoining shops were empty or closed. However, this depressed façade to the town did not match the vibrancy and friendliness of local residents. Community groups were active and innovative and residents I spoke to were committed to maintaining the viability of their town. Locals were able to choose from a variety of activities that included opportunities to play various sports, to worship at one of the 12 churches and one mosque or to attend exhibitions at the local art gallery adjoining the recently built library. A cultural mix of Anglo-European Australians, the local Nyoongar Aboriginal community and a small but significant Malay population, who were predominantly Muslim and many of whom were employed in the local halal meat works, added to town's diversity.

The Nyoongar people come from southwest of Western Australia and, prior to British settlement, were the recognised owners of their land. Their nearest neighbours were the Yamitjis to the north and the Wongkis to the east. Their cultural and religious beliefs were linked to their land and they believed that the Rainbow Serpent, the Wagyl, was their creator and the guardian of their sources of fresh water while they, the people, were the guardians of the land. The

Wagyl is currently the symbol used on the Bibbulmun Track to direct walkers along the path. Some of the Nyoongar groups living in the southwest included the Wordung, Mainitich, Bullaruck, Rarraruck, Didiriik and Tondariik and the Bindjareb, all part of the Bibbulmun people (Van den Berg, 2002). While Nyoongar people spoke the same language, there were many dialects. Research indicates that 13 linguistic groups lived in southwestern Australia though the groups' names differed from those compiled by Norman Tindall in 1940 (Green 1984 cited in Van den Berg, 2002: 6).

By the early twentieth century and after nearly one hundred years of white settlement, divisions between different ethnic groups were obvious. The social position of early white landowners in the area was symbolised by the Katanning Club. This gracious federation homestead complete with wide verandas, high ceilings and stained glass windows was located close to the town centre. Constructed in the early 20<sup>th</sup> century it was a 'members only' club and became a bastion of the white male establishment where landowners could go to have a drink and play cards when they came to town and meet those of the same ilk. Women were not admitted to the club except on 'Pigs and Ladies Day' (in that order) when farmers brought in their wives who could 'freshen up' before going out, having come straight from the farm. Women were eventually able to join years later where they formed their own club, the Marloo Club in the same building. Even now, as the homestead falls into disrepair, club rules apply and only members and invited guests are admitted.

From Katanning, I drove south to Gnowangerup past misty grey views of the Stirling Ranges, a rugged rocky outcrop with five peaks rising above 1000 metres that is a popular ecotourism spot providing the only alpine walks in Western Australia. Gnowangerup is about 60 kilometres southeast of Katanning deep in the heart of sheep and mixed grain growing country and about 360 kilometres from Perth. It is an area renowned since 1908 for stud merino sheep. The population of Gnowangerup Shire is nearly 1500 and one GP offers services in the area. Within the shire are the towns of Gnowangerup, Borden, Ongerup and the Stirling Range National Park. The town has wide open streets that add to its sense of space. A recently opened coffee shop, The Blue Baa, known locally as The Blue Bra, is run by two women residents who do the cooking. Sipping

one of their excellent cups of coffee, I noticed that everyone who enters the shop is generally known by name and greeted cordially as conversations ensue about crops, weather, family and gossip.

North-east of the City of Albany boundary is the Shire of Jerramungup which is 430 kilometres southeast of Perth. The shire began in 1982 and currently has a population of about 1200. A solo, overseas trained GP offers medical and pharmaceutical services from the main surgery four days a week in the town of Jerramungup. He also provides clinics at the branch surgery in Bremer Bay which otherwise operates as a nursing post. Bremer Bay is a popular tourist destination on the coast with the population swelling from 250 to over 5000 during peak season (South West People Care, 2002). The Jerramungup shire includes the towns of Jerramungup, Bremer Bay, Needilup, Gairdner, Boxwood Hill and Jacup.

The main highway from Jerramungup to Ravensthorpe is flanked to the south by the Fitzgerald River National Park, an area designated in 1978 as one of Australia's twelve biosphere reserves under UNESCO's Man and the Biosphere programme. A biosphere reserve is founded on the concept of people living and working with the environment in a sustainable way (SMEC Australia Pty. Ltd., 2002). Ravensthorpe, or Ravy as it is known locally, is nearly 300 kilometres east of Albany and 530 kilometres southeast of Perth. The town with a population of 350 people nestles in the Ravensthorpe hills that surround it to the north, east and southeast. The town enjoys expansive views of a patchwork of fields in plains spreading out towards the coastal town of Esperance. Ravensthorpe has a lively atmosphere and local residents are friendly and welcoming. The main surgery in the town offers the services of one overseas trained GP. Medical services are also provided at a clinic in the quiet, coastal town of Hopetoun with a population of 320 where I stayed in the local caravan park, in the hope of seeing any passing pods of whales making their way westwards. However, the place was deserted as strong winds and three cold fronts buffeted the coast, a fact which may have also have deterred the whales. The shire of Ravensthorpe covers an area of 13 553 square kilometres with 242 kilometres of sealed roads and about one thousand kilometres of unsealed roads. Two thirds of the shire remain as natural bushland,

including the Fitzgerald River National Park. Evidence of its mining history is seen in abandoned mine shafts dotted about the area.

After a couple of days in Hopetoun I drove north-westwards to Lake King and Newdegate along a seemingly dead straight road on my way to Lake Grace which is located on the eastern edge of sheep and wheat farming land. I passed through mixed grain country where deep green fields of wheat stretched as far as the eye could see alongside splashes of yellow canola crops. The rainfall was noticeably less here with dried up river beds and salt lakes marking the landscape. There were few trees with mainly low-lying shrubs or ground cover. Sheep became more evident on the outskirts of Newdegate. The Shire of Lake Grace covers an area of 9245 square kilometres and stretches from Tarin Rock in the west to Hatters Hill in the east. It has a population of about 1500, and the town of Lake Grace has a 13 bed hospital and a new medical centre built in 2000 for the services of a doctor and dentist. One overseas trained GP is provided with premises to offer surgeries at Lake Grace and Newdegate.

I drove from Lake Grace to Hyden, east of Kondinin, an empty road with vast tracts of open plains interspersed with salt lakes in relatively flat country. Kondinin is located in pastoral country about 100 kilometres north of Lake Grace. The town offers agricultural services although many retail shops were empty in the main part of the town. Kondinin Shire comprises 7340 square kilometres and forms part of the eastern wheat belt of Western Australia. It includes the towns of Kondinin, Hyden and Kalgarin with an overall population of nearly 1000. One overseas trained GP serves the area and offers surgeries in all three towns. Hyden draws the tourist dollar because of its proximity to Wave Rock, a few kilometres to the east. This is a significant attraction considered by geologists to be a freak rock formation sculptured in the shape of a wave and coloured by chemicals and wind over millions of years.

Pingelly, 173 kilometres southwest of Kondinin, began as a shire in 1961. It is an attractive town situated in well established pastoral country covering an area of 1294 square kilometres about 280 kilometres southeast of Perth with many impressive federation style buildings. I drove to Pingelly whilst being based in the service town of Narrogin, about 50 kilometres away. Pingelly offers

the services of one overseas trained GP who holds his surgery in the local hospital and draws patients from the nearby shire of Brookton and smaller outlying locations such as Popanyinning, a hamlet on the Hotham River.

About 90 kilometres west of Pingelly is the town of Boddington which was an easy drive from Narrogin. It has a population of about 1400 served by one GP. Boddington was gazetted as a town in 1921 and is about one and a half hours' drive from Perth. This area offers a diverse landscape of rivers, wooded areas, state forest, undulating pastoral land and small hobby farms. A nearby bauxite mine offers employment. There is a noticeable presence of young people and three hundred students attend the local district high school.

A fifty kilometre drive south of Pingelly took me through rich agricultural land to the service town of Narrogin with a population of nearly 5000. The town was gazetted as a municipality in 1906.<sup>15</sup> Narrogin is located in a prosperous farming region that produces grain, sheep, pigs and cattle and supports a substantial sheep and stud breeding industry.<sup>16</sup> It is a vibrant town 192 kilometres from Perth and 280 kilometres from Albany. Narrogin is situated in a high valley and offers a variety of services and retail outlets including several restaurants and cafes, a library, and a strong sporting culture. It exudes an air of prosperity that is reflected in well preserved, gracious federation homes and commercial buildings, few empty shop fronts, well-kept gardens, an impressive hospital and no less than four coffee shops in town. The Dryandra Woodland north of Narrogin is 28 000 hectare bush sanctuary for the conservation of wildlife including the rare numbat and woylies. This conservation area also attracts tourists and offers self-contained accommodation in traditional workers' cottages and facilities for camping, bush walking and cycling. Eight GPs, most of whom trained overseas, offer surgeries from two general practices.

Wagin is located in the middle of two service towns, Narrogin and Katanning. It is situated in rich pastoral land where I drove through a patchwork of colour in spring between fields of golden canola, bright green wheat shoots

---

<sup>15</sup> See <http://www.narrogin.wa.gov.au/> for more information

<sup>16</sup> See <http://westregional.com.au/papers/no/>

and brown fallow land. This gracious town with the ubiquitous wide streets flanked by impressive federation buildings includes an old colonial pub on the corner of the main street which doubles up as a restaurant and coffee shop. The population of Wagin shire is over 1800 and the town is located within the shire, an area of 1950 square kilometres. Medical services in the shire are provided by a solo, overseas trained GP who works in a brand new, light filled surgery as part of a health care centre.

On the main Perth to Albany highway over 150 kilometres north of Albany is the town of Kojonup in the midst of prime sheep country and rolling pastures of mixed agricultural farming. Kojonup has a population of over 2200 many of whom contribute to the local community newsletter informing residents of various activities in which the community is involved. Like other rural shires with small populations, one solo GP provides surgeries in Kojonup and also offers limited medical services in the local district hospital. Kojonup also has a district high school for students up to Year 10. According to one local resident, many of the youth leave the town 'as there is nothing for them here'.

## **History**

The southwest of Western Australia formed part of a large cultural block that covered land occupied by the traditional Indigenous owners, the Nyoongar. The land around Albany was part of the traditional country of the Minang group. Members of this group had little immunity to diseases introduced by British settlers with many dying from the common cold, whooping cough, flu, measles and tuberculosis (Day, 2000).

Albany is the oldest European settlement in Western Australia and was settled by the British in 1826 following orders from London to the Governor of New South Wales to secure the area after repeated sightings of French vessels off the coast. Settlers arrived by the Brig Amity on Christmas Day led by Commandant Edmund Lockyer (Day, 2000). Albany was declared a military outpost in 1827. It was not a penal settlement and the first free settlers arrived in 1831. In 1832 Governor Stirling officially named the settlement Albany after the Duke of York and Albany. Albany was originally a major whaling station and shipping port: the whaling station opened in 1835 and Albany's first exports to

London were whale oil, sealskins and wool. By 1851 Albany had become the mail port of Western Australia which led to a boost in the local economy and port facilities being upgraded. Convict labour built the road from Albany to Perth in 1853 and contributed to the expansion of the labour force and local economy. This was further boosted by the construction of the Great Southern railway which was opened in 1889 and led to an increased demand in the burgeoning local timber industry (Day, 2000).

Between 1900 and 1928 large tracts of land were subdivided and offered to British migrants to encourage them to settle in the southern part of Western Australia. However, the Great Depression led to widespread unemployment and full employment did not return till after the Second World War. By the 1960s, key elements in the Australian economy were agricultural growth, expansion and development. The Albany to Perth rail service closed in 1978, replaced by a bus service as road travel became easier with bitumen roads. In the 1970s, agriculture began to diversify as a result of low wool and beef prices. Tourism began to expand and new schools were built around this time (Day, 2000).

The first hospital was built in Albany in 1829 and the current hospital was opened in 1962 (Walker, 1963). Dr Alexander Collie, who lived from 1793 to 1835 was a surgeon and the first government resident in Albany after control of the settlement had been transferred from New South Wales to Western Australia (Johnson, 2001). Early medical practitioners in Albany had a dubious history. In 1868 Dr Cecil Rogers was the local doctor and health officer for Albany and was well known for being 'obnoxious' and 'had little time for his patients' (Garden, 1977: 166). In the 1850s and 1860s local doctors William Finer and Johannes Antonius Baesjou suffered from deep depression and went insane allegedly as a result of the community's lack of faith in their medical expertise. Finer was taken to an asylum and Baesjou slit his own throat.<sup>17</sup> Little is known of the provision of medical services in areas other than Albany at that time.

---

<sup>17</sup> Garden (1977) accesses this information from the Perth Gazette Newspaper 20.5.63 and the CSO (Colonial Secretary's Office) 256/107.

European settlement of townships began at various points during the nineteenth century. The area around Jerramungup was explored by the surveyor, John Septimus Roe in 1848 on his way to Esperance. The second part of the 19<sup>th</sup> century and much of the twentieth century saw conflict between white settlers and the local Aboriginal people, wandering sandalwood cutters and itinerant drovers.

The township of Jerramungup did not come into existence until 1957 after the Hassell family, the original British family who settled in the nineteenth century and farmed the land, sold their large farming property in 1950 to the Land Settlement Board.<sup>18</sup> The area from Jerramungup to Ravensthorpe was littered with disused mine shafts reflecting its gold mining history. Copper mining also contributed to the local economy until it ran out in the 1960s. However, mining in the area led to the development of a port at Mary Ann Haven, later Hopetoun, and a rail link between Hopetoun and Ravensthorpe. The disused rail track is now a popular walking spot. In 1868, Ravensthorpe and the area around Hopetoun were first settled by the Dunn brothers who began a sheep station assisted by Aboriginal shepherds.<sup>19</sup>

Historical information accessed from local websites, town libraries and tourist bureaus visited en route revealed that John Septimus Roe also explored the country around Lake Grace and Kondinin in the late 1840s and was assisted by the local Aboriginal community. The land in this area was eventually settled by pastoralists and was opened up in early 1900s for sheep and timber production, including sandalwood and wheat. The town of Kondinin was founded in 1909. Several hundred kilometres to the southwest, the first settler arrived in Pingelly in 1846 and farmed 4000 acres. Permanent settlement began in 1860. The Perth to Albany railway led to an economic boom in the area and by 1898 the population of Pingelly was 350. Local industry included farming, sandalwood, mallet bark and animal skins. The Pingelly shire council was formed in 1961.

---

<sup>18</sup> See <http://www.walkabout.com.au/locations/WAJerramungup.shtml>

<sup>19</sup> See: [http://www.travelmate.com.au/Places/Places.asp?TownName=Ravensthorpe\\_%5C\\_WA](http://www.travelmate.com.au/Places/Places.asp?TownName=Ravensthorpe_%5C_WA) and <http://www.accommodationguide.com.au/sitemap/racv/Golden-Outback-ravensthorpe.shtm>

The larger town of Narrogin emerged as an important centre in the late 1880s and became a major rail link during the construction of railways to Albany, Beverley, Collie, Wickepin, Kondinin and Dwarda. Narrogin attracted agricultural service industries as well as government departments and agencies. Boddington, to the west, was gazetted as a townsite in 1912. From 1937 commercial tannin production from white gum timber was one of its main industries. Narrogin was gazetted as a municipality in 1906 and remained a major rail centre until the late 1970s when competition from road transport and improved roads reduced the railways workforce from 280 people to less than a dozen in 1995.<sup>20</sup> White settlers began arriving in Wagin from 1840 and the town of Katanning was founded in 1889 when the Great Southern railway between Albany and Perth was completed. Drovers and shepherds also arrived in the area following the sandalwood cutters. New settlers were attracted to fertile farmland in the early 1900s particularly as both commodity prices and the demand for labour were high. Small communities around the town also flourished. After the Second World War cultural diversity increased as European migrants came to the town looking for work. Malay people from Cocos and Christmas Islands also settled in the area.<sup>21</sup>

Sandalwood cutting was also an early industry in Gnowangerup, southeast of Katanning. Information from the Shire of Gnowangerup, which drew on research by Merle Bignell in her book *The Fruit of the Country*, indicates that the meaning given to Gnowangerup by the local Nyoongar people was ‘place of the mallee fowl’. Traces of Aboriginal history are also evident in the stone implements found along the creeks. Such finds suggest that these areas formed some of the hunting grounds of the Goreng Nyoongar. During the nineteenth century, sandalwood cutting played an important role in the shire’s history. A sandalwood cutters’ camp was established at Borden in the 1840s about 35 kilometres east of Gnowangerup.

---

<sup>20</sup> See: <http://www.narrogin.wa.gov.au/> for more information.

<sup>21</sup> Information from tourist bureau and informal discussions with local residents and also from <http://www.katanning.wa.gov.au>

Several years after the founding of the Swan River Settlement in 1829,<sup>22</sup> later Perth and Fremantle, Alfred Hillman was sent north by Governor Stirling to blaze a trail from King George Sound (Albany) via York to the Swan River Settlement. He was guided by local Aboriginal people to a freshwater spring in what is now Kojonup. His favourable report back to Governor Stirling resulted in setting up a military outpost to protect travellers and the mail. European settlers were first attracted to Kojonup in 1837 because of the availability of fresh water. The word 'Kojonup' is a derivation of the Aboriginal word 'koja' meaning 'stone axe'. Overlooking the spring is the old Military Barracks, constructed in 1845 and one of the oldest surviving military buildings in Western Australia.<sup>23</sup>

South of Kojonup and east of Mount Barker is the Stirling Range, which was named by John Septimus Roe in 1835 after first Governor of Western Australia, Captain James Stirling. Governor Stirling explored Mount Barker in 1831 and a military garrison was stationed there in the 1830s. The town, like many others, developed further with the construction of the Albany to Perth road and railway lines. Given the temperate climate of Mount Barker, apples contributed to the early growth of the town.

Information from the local tourist office and library indicates that there is also archaeological evidence of Aboriginal occupation in the area around Denmark. Low stone walls, possibly around 3000 years old were found in the Wilson Inlet in Denmark and were used by local Aboriginal communities to trap fish. Stone chips have also been discovered in places where stone tools were made. The town of Denmark was established in 1895-1896 by white settlers, mainly because of the huge demand for timber for export to the United Kingdom and Europe, Africa, India, China and the United States of America. By 1905, the forest had been felled which eventually led to closing down the mills and Denmark became a virtual ghost town. Early settlers began farming in 1906 and established vegetable gardens and orchards for home consumption and income and by 1911 dairy farming began as an industry. The 1920s saw the beginning of

---

<sup>22</sup> See: <http://www.newmanjunior.wa.edu.au/West/swan.htm>

<sup>23</sup> See: <http://www.kojonup.wa.gov.au/html/kojonup.htm>

the tourism industry. More recently, after the Second World War to the mid 1970s, cattle grazing on former dairy farms began. Sheep were also introduced and the timber industry recommenced in response to the building boom. From the 1980s, in the face of rural decline, Denmark's population increased to become one of the fastest growing population centres in the Southwest of Western Australia. It was seen as an attractive location for retirees or those interested in farming on small rural properties and people preferring an alternative lifestyle. Agricultural diversity continued with an increase in the land used for vineyards and growing wildflowers (Conochie, 1990). It also became a popular tourist destination.

### **Rural economy**

The Great Southern region of Western Australia currently has a mixed economy drawn mainly from sheep and mixed grain farming, viticulture, and, to a lesser degree, mining and fishing (Great Southern Development Commission, 2003). The region is a premier producer of fine wool and is the second largest wool producing area in Western Australia as well as being the state's second largest meat producer, mainly from the slaughter of sheep and cattle. Its primary industries include broad acre cropping, wool, livestock, horticulture and fishing all of which constitute the mainstay of the economy. Other crops include grapes to support an expanding wine industry in specific areas around Albany, Mount Barker and Denmark. Aquaculture is also being developed in addition to fishing. Land is also used for blue gum plantations which have increased in popularity as a commercial venture. The manufacturing industry supplies equipment and machinery to the farming sector and processes agricultural commodities. After sharp falls in 2000-1 the construction industry is recovering and commercial activity in the region has been expanding. Tourism continues to show strong economic potential for the future (Great Southern Development Commission, 2003).

Many areas in the region outside Albany run sheep and harvest mixed grain crops. Some local economies are diversifying with Jerramungup operating a fish processing plant and Lake Grace occasionally harvesting yabbies or freshwater crayfish as well as growing grapes for wine. The mixed grain and

sheep farming has also diversified in Boddington and Pingelly where ostriches, emus and alpacas are farmed. Katanning, as the largest stock selling centre in Western Australia, also produces high yields of cereal grains and has opened an halal abattoir where many in the local Muslim Malay community now work. Mining operations for Silica sand and spongolite are carried out in the area (Great Southern Development Commission, 2003) and a nickel mining operation is soon to commence outside Ravensthorpe. While Boddington is noted as a top wool and coarse grain producing area, it is also mined for bauxite and gold. Information from the Shire of Kojonup reveals that new initiatives have been implemented such as the Recycling Program and the Kojonup Soils Centre that is being developed in partnership with the University of Western Australia. It offers an unbiased soil analysis service for farmers on a commercial basis.

Tourism is developing in the region covered by the GSDGP even in the more remote locations. The coastal areas from Walpole in the west to Hopetoun in the east are popular destinations and the natural beauty of the Stirling Ranges and the Porongurups, an area dominated by karri forest, is also a drawcard to explore inland areas. The Gnowangerup Aboriginal Corporation offers tours of Koik-yen-nuruff (Stirling Ranges) that focus on the cultural heritage and history of the Nyoongar people in that area, as well as information about bush foods and traditional medicines.<sup>24</sup> Less well known tourist destinations are the more isolated areas. Kondinin draws the tourist dollar with the proximity of Wave Rock, a local geological attraction which is also important in local Aboriginal history as a site of cultural significance. The area around Lake King and Lake Grace offers windsurfing on the salt lakes. Information about local activities in many rural shires is available in community newsletters which are published locally in many of the small towns. The *Wagin Community Profile* informs the reader about some of the tourist attractions in the area including the Historical Village where original buildings have been either relocated to this site or recreated. It is staffed by volunteers and attracts fifteen thousand visitors

---

<sup>24</sup> See:

[http://www.albanygateway.com.au/Town/Gnowangerup/Gnowangerup\\_Aboriginal\\_Corporation/](http://www.albanygateway.com.au/Town/Gnowangerup/Gnowangerup_Aboriginal_Corporation/)

annually. Wagin also hosts the Woolarama, claimed to be the biggest sheep show in the southern hemisphere. It is an annual event that attracts 30 000 visitors.

Kojonup has recently opened 'The Kodja Place', a tourist attraction built around the theme of 'one story, many voices'. Mixed media displays present local Nyoongar culture intersecting with the rural history of white settlers in the area, particularly those from Britain and Italy.<sup>25</sup> Viticulture is centred round Mount Barker, Denmark and Albany and wine tasting is a favourite pastime with tourists. Information from the Plantagenet Shire Council claims that the shire is the largest wine growing area in the state where more than 1000 hectares of vines have been planted and all major grape varieties are represented. Farming has also further diversified from mixed grain and sheep to the increase in the timber industry with tree plantations occupying 780square kilometres or 22 per cent of freehold land in the shire. Mount Barker is situated in area of high biodiversity with a broad range of ecological species including karri forest, jarrah, marri and white gum woodlands and sand plains.

## **Rural restructuring and development**

While the populations of many inland and agricultural areas are decreasing (Tonts, 2004) those of the shires of Denmark and Plantagenet and the City of Albany are increasing. These three local government areas accounted for 76.3 per cent of the population of the Great Southern region in 2002 which is predicted to increase to 81 per cent by 2011 (Great Southern Development Commission, 2003). Using data from the ABS analysis of the 2001 Census, the Shire of Denmark 2003 *Local Planning Strategy* recorded that the population of Denmark increased by 18.2 per cent from 1996 to 2001 census compared to Albany which grew 9.65 per cent and the Shire of Plantagenet which grew by only 5.1 per cent. Other inland populations fell; Katanning by eight per cent and Kojonup by just over three per cent.

In rural areas, services are a 'significant element of community vitality and prosperity' (Cocklin & Alston, 2003: 2). Notwithstanding population

---

<sup>25</sup> See <http://www.kodjaplace.net.au>

decline, certain services are currently available in all shires including state primary schools for children up to Year 7. Albany offers more choice between private and public education. There are several primary schools, three senior high schools, colleges of Technical and Further Education (TAFE) and a recently opened University of Western Australia campus offering several undergraduate degree courses in Albany. Opportunities for post-secondary education and training are also offered through TAFE colleges located in Katanning, Narrogin, Mount Barker, and Pingelly.

Outside Albany, all but one shire has a District High School for students from Years 8 to 10; students from Kondinin shire have to travel to attend school in Kulin in the neighbouring shire. Some shires including Denmark, Gnowangerup and Narrogin also offer secondary education in agricultural colleges some up to Year 12. Buses are often provided for students not living in the areas but who choose to attend Years 11 and 12 in Senior High Schools. Senior High Schools are also located in Narrogin, Katanning and Mount Barker. Narrogin Senior High School has 850 students including 240 from the environs who stay in a local residential college. Katanning also has a residential college for students from out of town though numbers are lower than in Narrogin. Some parents choose to send their children as boarders to a private school in Perth, usually for their secondary education.

Community participation in local activities forms a significant aspect of life in rural locations and contributes to the sustainability of rural towns. Activities that range from sport, to supporting local schools and hospitals, to recreational pursuits including arts and crafts, to worshipping at local religious institutions are some of the areas of interest. In Kondinin there are over 30 different community groups offering social support and a sense of belonging from activities that include meals on wheels to the local gardening club. The town of Kondinin with a population of about 300 offers at least 15 sporting clubs. Boddington provides six floodlit hard tennis courts for the community, a swimming pool, an 18 hole golf course, three netball/basketball courts, a full size grassed oval for cricket, hockey and football and another smaller one, a pony club, rifle range, cricket practice nets, two bowling greens and facilities for badminton. Wagin offers 54 clubs or organisations, 23 are involved with sport,

including the aero club and the trotting club. Sporting facilities in the town include a six lane, 50 metre swimming pool, ten tennis courts, a bowling club, a trotting track, facilities for go-karting, hockey, netball, horse trials, basketball and badminton. Narrogin has over 60 sport and recreation clubs, including football, tai chi, a repertory club and a clay pigeon shooting club. Service clubs such as Rotary or Apex are also well represented. Pingelly offers at least 18 sports and recreation clubs and six Christian churches to sustain a shire population of about 1200. Narrogin has 13 Christian churches or places of worship as does Katanning. Katanning recently built a new public library to which is attached an art gallery offering exhibitions and space for local and national artists to display their work.

Rural communities also want adequate provision of health care services where having a local GP is considered a top priority. While there were 60 GPs working in the GSDGP when this research was undertaken, their main surgeries were located in 14 of the 25 shires in the region. GPs mostly worked in private practice with one exception where the GP only bulk billed his patients. Bulk billing allows patients to allocate their Medicare rebate directly to the GP who accepts the rebate as full payment for his/her services (Australian Government Department of Health and Ageing, 2005). General practices elsewhere can selectively bulk-bill their patients. Emergency and aged care are often available in District hospitals in all shires offering GP services. Individual GPs can apply to the Health Department of Western Australia for visiting rights to the local hospital in the location in which they work. However, procedural work such as obstetrics and surgery is only available in larger centres. The City of Albany offers a 120 bed hospital that provides residents in the region with specialist services including surgery, chemotherapy, obstetrics, mental health, rehabilitation, paediatrics and day procedures as well as a comprehensive range of outpatient clinics including cardiac rehabilitation, endoscopy and specialist wound care. The majority of patients in the hospital are under the care of their local GPs.

While many rural communities are seeking the services of a GP, medical services in Narrogin are not considered a problem by the local shire council. The success of the town is such that the shire has offered few incentives similar to

those provided by other rural shires such as free housing to attract and keep GPs. Instead, GPs have generally arranged their own accommodation and surgery premises. Several GPs who have worked in the town have stayed over ten years, some over twenty years. There are no salaried doctors working at the 51 bed district hospital and all local GPs have Visiting Medical Officer (VMO) rights to attend their patients at the hospital. Recently one of the practices applied for funding as an area of unmet need to attract the services of another GP. This was granted and hence the practice was able to offer subsidised housing to the incoming overseas trained doctor.

Many smaller hospitals outside the large and medium rural centres have been downgraded in the current political economic climate although they continue to offer reduced services. Kondinin has eight beds, five for acute care and three are allocated as nursing home beds. It also offers 24 hour accident and emergency services, minor surgery, paediatric, ante-natal, post-natal and aged and extended care. There is also a modern 18 bed accredited hospital in Wagin which includes a palliative care ward and a hostel for the frail aged located next to hospital. Gnowangerup District Hospital was built in 1930s and has 17 beds. It offers emergency medical care, allied health and an aged care unit which has its own vegetable garden tended by residents. Kojonup also has a local hospital and facilities for the aged.

## **Providing rural health care**

Discussion with one resident stallholder at the local Saturday morning markets in Albany centred on his perception of the lack of government support for the sustainability of rural communities. Greg (pseudonym) was concerned that governments failed to appreciate the effects of rural restructuring and development on the social fabric of local communities. He argued that reducing services in rural locations did lead to job losses and people leaving to find work elsewhere, a move which effectively threatened the viability of some of the smaller towns. As populations dwindled, keeping local businesses commercially viable became more difficult. This sometimes resulted in amalgamating services with other smaller communities which, he thought, undermined discrete communities' sense of belonging to, and identity with, 'their' town. Greg saw

this development as further evidence of governments making it more difficult to attract new businesses, let alone GPs, to work in areas where this downturn was occurring. Greg's comments draw attention to the wider effects of political and economic changes on social practice in rural communities

In order to understand the process of recruiting and retaining GPs more specifically, I contacted those directly involved at the local community level. This led to discussions with six Chief Executive Officers (CEOs) of local shires in the GSDGP and two shire councillors as well as six Health Service Managers/Directors of Nursing (HSM/DONs) who worked closely with GPs. I also met local representatives from health services, community development and several community residents in order to discuss their responses to the recruitment and retention of GPs and their families. These discussions provided a broader understanding of issues relating to the delivery of rural GP services and an opportunity to reflect on hegemonic views regarding medico-centric approaches to rural health care delivery. In this context, differences emerged within and between groups regarding the solution to the rural health problem being one of providing more doctors.

Several CEOs of rural shire councils and HSM/DONs commented that the capacity to provide medical services locally constituted a significant drawcard for people to live in the area. It also had the added advantage of attracting others to the area to use the medical services. One CEO commented that, without a GP, local residents attend medical services elsewhere and inadvertently undermine the commercial viability of their own town by patronising other businesses in the town where the GP is located. This is particularly relevant when considering the effect of neoliberal policies on the restructuring and development of some rural centres where hospitals have been downsized and services such as banking reduced or closed as populations dwindle (Cocklin & Alston, 2003; Tonts, 2000). Such structural changes affect the lives of those already living in the area and impact on people's decisions to move to the area.

Banks and other businesses that withdraw services not considered economically viable appear to lack an awareness of the social costs to the

community. Job losses may lead to out-migration if employment opportunities are unavailable. The viability of the community itself may be at risk particularly in isolated locations where residents have to travel further to access a range of services. Attracting GPs is made more difficult if the social and economic fabric of the community is compromised as a result of rural restructuring. This presents a challenge to many rural shire councils who want to attract the services of a GP and find ways to keep them in their area.

Rural shire councils are involved in recruiting and retaining GPs. Historically, many were responsible for recruiting GPs themselves, an expensive and time consuming exercise with no guarantee that the GP would remain in the area. One CEO commented that advertising alone could cost thousands of dollars and, if the GP decided to leave, the process would have to be repeated. Costs to recruit and retain the services of a GP came out of the overall annual budget already allocated to the local shire council by the state government. According to another CEO, local government receives insufficient resources from state and federal governments to ensure medical services are run effectively. He argued that, in the current political and economic climate, the state and federal governments saw the bottom line in economic rather than social terms. In other words, he argued that their objectives were less about meeting the health needs of the local community in the most effective way, and more about shifting costs, balancing the budget and making cuts where necessary regardless of the social effects. He commented that this perspective highlights 'the difference between running a service and running a business'. Another CEO discussed the fact that money spent on GP services may leave a community with insufficient funds to provide other necessary services such as constructing and maintaining a sports oval that also contribute to the health and welfare of the community.

Several years ago, the process of recruiting GPs to work in rural locations often generated competition between shires where, according to another CEO, bidding wars ensued: shires with greater resources were able to offer more incentives to attract GPs and their families than those with a more limited budget. This process revealed the diversity among rural communities in terms of economic resources that often reflected deep-seated inequities in the capacity to provide medical services. In the last five or six years this method of recruitment

and retention has changed. Most of the smaller shires in the GSDGP, particularly those needing a solo GP, have enlisted the services of private industry where recruiting agencies will often guarantee to provide a GP for the community, shoulder the advertising costs of attracting a GP, often overseas trained, and sometimes take over the management of the general practice, including paying staff wages, leaving the GP free for clinical work. Recruitment agencies may also agree to find locums if the GP goes on leave. In return, the shire council pays the agency an annual fee of several thousand dollars and often provides the surgery premises in which the GP works. In addition, the shire council might negotiate with GPs incentives from its annual budget with incoming GPs and their families. These may include a rent-free house and car and, sometimes, payment of domestic utility bills. Four shires with solo GPs were in the process of constructing, or had already built, large, four or five bed-roomed houses or were renovating older houses at no cost to the GP. According to one CEO, the local GP's newly built home was 'one of the best houses in town'. Another shire also guaranteed the GP a minimum annual gross income in addition to providing him/her with a house. If the GP exceeded this amount, he/she was entitled to keep the profit; if not, the shire would pay the difference to the agreed amount. GPs were usually required to pay a percentage of their income to recruitment agencies for managing their practices.

One CEO approved of allocating a proportion of the annual budget to paying a recruitment agency to provide the local community with the services of a GP. The same CEO commented that a top priority for many rural communities was to have a local GP working in their town. Other CEOs looked at the issue more broadly and claimed that local GPs did not just provide medical services but contributed to the economic sustainability of rural towns. Not only did job opportunities increase in the health sector, but also people were more likely to want to live and work in the town if they knew medical services were available. Without such services one CEO commented that residents went elsewhere to access medical care. This often led to residents using other services in the town where the GP was located, such as shopping for food and fuel, which drained the local economy of their own town.

HSM/DONs' involvement in recruitment and retention of GPs varied. While some actively participated in strategies to attract and keep doctors working in their communities, others' contribution to the process was minimal. One HSM/DON fostered a spirit of collaboration and negotiation with local GPs, all of whom were overseas trained, by supporting them professionally, socially and economically. She commented that many OTDs from culturally and linguistically diverse backgrounds arrived with little financial capital and needed support till they established themselves and she encouraged community residents to participate in the process. This translated pragmatically into the HSM/DON working with the local shire council to find an appropriately located surgery building and the resources to refurbish it. The HSM/DON also suggested Rotary organise a dinner to welcome GPs and their spouses and introduce them to local community members. She encouraged local business to become involved in the process of helping GPs and their families settle in. This resulted in one local car dealer offering to offer cars to two new doctors where payments could be waived till they 'found their feet financially'. In another shire, the council regularly met the new GP with a view to looking after the personal welfare of the GP and his/her family and to 'check everything is OK'. One HSM/DON commented that, in the past, rural communities had expected local GPs to stay 'for ever'. While several GPs had practised in the same location for over 20 years, the HSM/DON suggested that such expectations were unrealistic. She regarded the higher turnover of GPs as 'not such a bad thing' given that new GPs brought new ideas and practices that could benefit the community.

CEOs and HSM/DONs incorporated other ways to encourage GPs to stay. These included attempts to modify community expectations that GPs were available whenever anyone was sick. This was no easy task. Medical care remains an important element in rural communities' notions of what constitutes health care. One HSM/DON commented that, in her experience, many people rely on the health system, including the GP to solve non-medical issues. She suggested that rural communities often sought responses to social problems from within the health system rather than seeking support from other sources such as the extended family or the wider community. She observed residents in the town in which she lived who expected 24 hour availability if they were sick or needed

help and felt they ‘owned’ the GP. She commented that if locals saw the GP’s car in the driveway of his/her home, they would knock on the door and request his/her services. A CEO in another shire discussed the need to educate local residents about appropriate boundaries in their relationship with their GP. He suggested that if residents realised GPs needed time off in order not to become overloaded, and therefore more likely to leave, then they might change their behaviour and become less demanding of GPs outside surgery hours unless there was an emergency. Members of one shire council actively discussed with local residents ways to raise awareness of the issue and followed up with letters to the editor of the local newspaper. These strategies showed the commitment of local shires to encouraging the community to become actively involved in finding ways to persuade GPs to stay.

The issue of recruiting and retaining GPs could also be a site for contention. Informal discussions with local residents revealed that the dominant position GPs held in the health hierarchy, as well as their position of privilege within the social organisation of the community, sometimes created dissension. One shire councillor commented on the perception amongst some residents of the divide between doctors and the rest of the local population. She claimed that the generous financial inducements offered to GPs and their families to work in a rural location reflected their privileged status and set them apart from others in the community. Some residents of smaller rural centres raised the issue of inequity with comments that that rural GPs are given too much. They pointed out the lack of incentives offered to other professions and workers who also contribute to community sustainability. At the opening of an art exhibition in Albany, a fourth generation rural resident and shire councillor bemoaned the elitist treatment governments accorded rural GPs and discussed the notion that community sustainability rested as much on residents providing businesses and services that supported the viability of the town as it did in providing doctors. In one agricultural service town, this shire councillor commented that diesel mechanics were important but ‘who offers them subsidised housing and a new washing machine?’

The need for the services of a GP at any cost was also contested amongst health professionals. One HSM/DON observed that, when the GP is not

available, the community uses the services of nurses at the local hospital or nursing post. Nurses often have back-up support from the GP who may be located in another town, the local hospital or the Royal Flying Doctor Service (RFDS) if necessary. However, the HSM/DON commented that rural nurses seldom receive adequate recognition for the work they do. Even with a local GP resident in the town, another HSM/DON mused that she assesses patients in hospital and informs the GP who phones through orders. As a result, she would take blood from patients, run electro-cardiographs (ECGs), insert intra-venous infusions and stitch up patients; services that were historically provided by GPs. A third HSM/DON questioned whether a GP was necessary in some smaller towns given their proximity to larger centres with medical services.

Discussions with HSM/DONs provided opportunities to consider innovative approaches to rural health care. While difficulties attracting rural GPs were understood, potential solutions ranged from employing government salaried doctors to work in rural hospitals to increased recognition of the role of rural nurses play in providing health services, particularly when a doctor is not available. Some HSM/DONs commented that employing salaried medical practitioners might generate tension amongst local GPs in private practice whose visiting rights to practise in hospitals and perform procedural work might be threatened. A major advantage of rural general practice and a source of professional satisfaction for many GPs was the opportunity to carry out procedural work on their patients. In this context, doctors were able to exercise their autonomy and take control of decisions regarding the care of their patients in hospital and maintain their own procedural skills. This process was unlikely if they lived in metropolitan centres where decisions about patient care in hospital were generally made by specialists. Some HSM/DONs commented that hospital work was also very lucrative for rural GPs comprising, on average, around one third of their overall income.

Individuals working in community development and health care in the Great Southern region discussed the notion of diversity between rural communities when considering health care needs. Some suggested that, rather than providing more GPs as a one-size-fits-all solution, exploring solutions 'outside the square' was also important. Suggestions included the increased use

of technology such as Telehealth which draws on electronic information and interactive communication technologies including video-conferencing to deliver health services to those living in remote locations with no access to GPs.<sup>26</sup> However, this approach presumes access to, and proficiency in, working a computer or other relatively expensive technology in a rural environment where telecommunication services are often less than adequate. Other suggestion was to find the best way to appropriately meet health needs given the demographic differences between locations. Responses included placing more emphasis on health promotion and recognising cultural differences when considering health needs. Evidence of the latter is found in the Great Southern Family Futures Program based in Albany which includes an Aboriginal Health program funded by the Office of Aboriginal and Islander Health whose aim is to provide a holistic approach to the health care of Aboriginals and their families. It is also seen as an opportunity for the Nyoongar people of the Great Southern to have a voice in the delivery of health care programs to their community. This highlights the benefits of using Aboriginal health workers for health education and health promotion in local Indigenous communities. Medical services were accessed from GPs in private practice or from the public hospital.

While other health professionals may offer alternatives to the medico-centric approach to rural health care, the hegemonic status of medical profession in the hierarchy of health care providers persists. This has sometimes generated tension between the rural GP and the local HSM/DON or shire councillors who were unable to meet the GPs' demands for resources owing to budgetary restrictions. Such tensions were explained by some CEOs and HSM/DONs as personality differences or 'clashes'. However, this response may only paint part of the picture thereby maintaining the issue at the level of individual differences. A social perspective paints a broader canvas whereby the notion of a dialectical relationship emerges between structure and social practice. By widening the lens with which to view the problem reveals its complexity and offers a more nuanced

---

<sup>26</sup> For further information see:  
[http://www.gpcg.org.au/index.php?option=com\\_content&task=category&sectionid=4&id=58&Itemid=1131](http://www.gpcg.org.au/index.php?option=com_content&task=category&sectionid=4&id=58&Itemid=1131)

appreciation of how structural factors can cause conflict at the level of practice. Political and economic constraints on the delivery of services may conflict with the ideas and practices of rural GPs about appropriate ways to respond to rural health care. For example, GPs working in private practice may want access to resources to provide optimum patient care. They may also want to maximise their income with minimal bureaucratic interference in their work practices. However, their work practices intersect with the public sector, the local hospital. The HSM/DON of the local hospital is allocated an annual budget from the state government for health service delivery and may want maximum efficiency, cost containment and 'best practice' in health/medical care which may restrict how the GP practises. This may result in tension between the GP and the HSM/DON who is restricted by limited resources. However, as discussed earlier, fostering collaborative relationships between HSM/DONs and GPs opens the door to negotiation and the potential for change.

It is at this point that I shift the focus to hearing the views of GPs and their spouses on factors that affect their sense of enjoyment living and working in rural locations and that underpin their decision to stay or leave. To set the scene, the next chapter discusses methodological issues that include the process of gaining access to GPs and their spouses, the gathering and management of information and the analysis and interpretation of ethnographic material.

## **CHAPTER 4**

### **Methodological matters**

The value of ethnography ... is found, not in its analysis and interpretation of culture, but in its decision to examine culture in the first place; to conceptualise it, reflect on it, narrate it and ultimately, to evaluate it (Van Maanen, 1988: 140).

With these comments in mind, I chose an ethnographic approach to examine the expectations and experiences of rural GPs and their spouses for two reasons. First, the work of Spradley (1979) gave me an opportunity to seek to understand, using a variety of methods, how participants experience and attribute meaning to aspects of their life that influence their decision to stay or leave rural general practice. Spradley's approach paints a picture of the world from the participant's point of view. I also chose to expand on this picture by providing a backdrop in which to situate and deepen my understanding of their world. The second reason I chose ethnography was to locate participants' expectations and experiences in a broader social context and 'subject the insider's view to critical analysis' (De Laine, 1997: 124). This perspective offered an opportunity to examine the role of structural issues in social practice and identify relationships of power. In this light, 'patterns of domination of individuals and groups that stem from fundamental structures and ideologies of social systems' (De Laine, 1997: 125), often accepted as part of the 'normal' social order (De Laine, 1997: 127), could be examined in relation to notions of hegemony and symbolic violence.

Ethnography combines the perspective of both the researcher and the researched and requires that the researcher participate in and observe participants' actions and behaviour in everyday contexts rather than in experimental conditions (Hammersley, 1990). Hammersley (1992) argues that the contextual nature of ethnography, and the time taken to develop rapport and trust with those involved, more than any other methodological approach, assists in understanding more fully the cultural rules, norms and beliefs of a specific group of people that inform their actions and behaviour. As a model to guide the study it allows the observer to 'conceptualise ... reflect ... narrate ... and

ultimately ... evaluate' (Van Maanen, 1988: 140) a particular social group who live and work in a rural setting in the context of structural changes. The group attracting my interest in this project were male and female Australian trained rural GPs, their spouses/partners, and overseas trained doctors (OTDs) and their spouses, living and working in diverse locations within the area covered by the Great Southern Division of General Practice (GSDGP). Some OTDs and their families were from culturally and linguistically diverse backgrounds, their experiences adding complexity to the picture. Gathering information from the group as a whole reveals 'historically, politically and personally situated accounts, descriptions, interpretations and representations of human lives' (Tedlock, 2000: 455) that reflect the diversity of their experiences. It is this diversity at the level of social practice that, according to Chesters et al (2001), challenges essentialist views of rural experience. Instead, it deepens understanding of issues that contribute to both the difficulties and benefits of living and working in rural locations. Whilst recognising 'the role of prior theory in framing both the context of the data and how it is analysed' (Rice & Ezzy, 2001: 191), I adopt an inductive approach that allows new insights to emerge as a result of empirical observation that can build on existing theories (Strauss & Corbin, 1994).

## **Background**

This project was carried out in a cultural setting known to the researcher which, according to Spradley (1979: 50), can make the analysis of information more difficult because much is taken for granted due to familiarity with the cultural knowledge. On the other hand, much can also be gained as a result of that familiarity. As Scholte (1972) suggests, researchers bring their own experience, cultural background, values and understandings to the fieldwork experience. Indeed, the prospects of gaining access to participants can be increased when researchers' interests and/or experiences may reflect those of participants (Shaffir & Stebbins, 1991). Danziger (1979) studied doctor/patient interactions during pregnancy and childbirth. Her identity as the daughter of an obstetrician informed her research in various ways. She was well aware of 'the firm resistance of doctors to an outside researcher' and observed the 'care

physicians take to circumscribe scrutiny' (1979: 515). She used her familiarity with medical culture to her advantage in helping to break down barriers and gain access to information by 'minimis[ing] [her] threatening outsider status' (1979: 516).

With this in mind, I used my own family background to assist the research process and build on my understanding of some of the issues faced by rural medical families. I grew up in a medical family where my father was a doctor and my mother a nurse. I have three sisters all of whom became nurses and married doctors, two of whom are GPs currently working in rural general practice. I also became a nurse and married a doctor and we were together for over 20 years before eventually separating. I lived as a rural GP's wife for many years in a small Australian town, both of us having migrated to Australia. I was able to understand aspects of medical culture by using this knowledge and experience which often helped me to gain access and engage participants in the project. I was able to build rapport and shape my questions in interviews in light of my experience which provided a deeper understanding of issues when analysing and interpreting information. Familiarity with cultural knowledge seems particularly relevant given the challenges faced by those who 'study up' by researching elite groups within Western industrialised societies, particularly when it comes to access. According to Bell (1978: 15), 'studying up' focuses on the fact that those who control society 'define who others are, the parts others play, the parts they as controllers play as well as notions about 'society' as a whole'. In other words, 'studying up' can show how hegemonic relations are constructed and reproduced. However, Nader (1972: 302) acknowledged that power elites are difficult to engage as they are 'out of reach on a number of different planes: they don't want to be studied; it is dangerous to study the powerful; they are busy people'. Aware of such potential obstacles, I drew on my own cultural knowledge as a way to gain access to participants which was generally, though not always, successful.

## **Gaining Access**

Feldman, Bell and Berger (2003) and Maginn (forthcoming) agree that gaining access is a crucial aspect of research yet analysis of the topic is relatively

absent in contemporary research methods literature. Maginn suggests that this implies gaining access is a straightforward process and not in need of investigation. Some researchers, notably Hammersley and Atkinson (1995) and Shaffir and Stebbins (1991), argue that gaining access to research sites and/or participants can be anything but straightforward. My own experience reflected the findings of Feldman et al (2003) who suggest that gaining access is an ongoing relational process where the researcher builds relationships with participants that form part of an ongoing, dynamic interaction involving negotiation and re-negotiation. For practical purposes, the authors break down the concept of gaining access into several stages that include finding informants, seeking approval to contact informants, entering the field and making initial contact, building rapport, developing and sustaining relationships and leaving the field. I loosely follow this framework to inform my own methods of entering the research site, finding informants and sustaining relationships.

Gaining access to an elite group also offers opportunities to add to 'studying up' theories by taking into account the role that GPs and their spouses play in the social organisation of rural communities. Given the difficulties previously mentioned in researching the medical profession as an elite group, I devised various strategies to encourage their participation, partly based on my knowledge and experience of that social group. I decided that presenting the project to potential participants in various stages over a few months was preferable to 'going in cold' when I arrived in the field. The rationale behind this decision was to slowly introduce GPs to the project, keep the door open and minimise the possibility of outright rejection.

### ***Finding informants***

In order to identify my potential key informants, I sought assistance from the Industry Partner, the GSDGP, involved in the funding of this research. This organisation had access to all GPs working in their Division. In 2002, seven months before I arrived to commence fieldwork, I visited their main office in Albany to meet staff and gather preliminary data about the demographic distribution of GPs living and working in the GSDGP and to discuss effective ways I could establish contact with them and their spouses/partners. I discovered

that the Division organises regular continuing medical education (CME) days as part of the professional development of GPs. I requested that I attend one of these before carrying out fieldwork to introduce my research project and meet some rural GPs. Participating in a local medical event allowed me to observe GPs who worked in the region and to establish face to face contact in the hope of engaging their interest in the project. I reasoned that, given the plethora of requests for information rural GPs receive in the mail, they were less likely to reject my request if they had already been introduced to the project and/or we had already met and discussed it.

At an ensuing CME day I was allotted ten minutes before the morning tea break to introduce myself, the project and my expectations of their involvement. I kept the presentation brief and informal and handed out a summary of my talk that provided information about the project and included my contact details. During the tea break, I followed up on the talk by approaching several GPs and chatted about where they worked, the research project and whether they would mind if I contacted them when I returned to do my fieldwork. All those with whom I talked agreed and gave me their names and contact details. One OTD talked at length about some of his and his wife's difficulties settling in and suggested I contact her too which I subsequently did. On the same evening, I attended a dinner organised by the GSDGP for GPs and their spouses. I took the opportunity to meet other GPs and to introduce myself to spouses and briefly explain my proposed research. I followed up on these contacts during the course of my fieldwork. One female GP stated at the end of our interview several months later that, had we not met and discussed the project at the CME day, she would not have been involved which validated my decision to introduce the project in stages.

Three months after I had presented the project, I was invited to attend a lunch in Albany for spouses of GPs in the GSDGP co-ordinated by the Rural Medical Family Network. This is a government funded organisation that offers social support to rural GPs and their families. About ten spouses attended and I explained the project over lunch and gave them printed information. I chatted with several, some of whom gave me their personal contact details and agreed to be interviewed at a later date. Meeting spouses in this way later proved

invaluable and I contacted all those I had met at the lunch, most of whom agreed to be interviewed.

### ***Ethical considerations***

Ethics clearance to undertake this research was granted by Edith Cowan University. Preserving the anonymity of participants has been a priority not least because researching a high profile group living and working in a rural area is challenging. While every effort was made to ensure protection of privacy of participants as far as possible, ‘watertight confidentiality’ is often ‘impossible’ as information is ‘often recognised by insiders’ (Christians, 2000: 139). I have made every effort to de-identify specific information such as names and workplaces to honour my commitment to respecting the privacy of participants. I have described locations generically by referring to them mainly as ‘rural’ in relation to GPs and their spouses. I have also used pseudonyms and, in order to reflect the diversity in responses within and between groups of doctors and their spouses, I have allocated each participant initials and a number (see Table 4). Classifications are as follows:

AMGP: Australian trained male GP

AFGP: Australian trained female GP

OMGP: overseas trained male GP

OFGP: overseas trained female GP

AMSP: Australian male spouse

AFSP: Australian female spouse

OMSP: male spouse from overseas

OFSP: female spouse from overseas.

**Table 4: Classification of GPs and spouses**

<b>GP</b>	<b>Number</b>	<b>Spouse</b>	<b>Number</b>
AMGP	1-13	AMSP	1-3
AFGP	1-5	AFSP	1-7
OMGP	1-12	OMSP	1-2
OFGP	1-2	OFSP	1-9

About two weeks before I was due to leave Perth to commence fieldwork, I mailed information to all GPs and their spouses in the Division. I had already

decided that my project would carry more weight in the eyes of GPs if it was endorsed by a medical practitioner. I contacted the Chair of the GSDGP, a local GP, whom I had met at the dinner following the CME day I attended, and asked if he would write a letter endorsing the project. He agreed, I drafted the letter on a GSDGP letterhead, emailed it to him requesting that he make any necessary changes and sign it (see Appendix 1a). I then sent that letter to GPs and spouses along with my own covering letter on the university letterhead, with my phone number and email address explaining that I would contact them in the next few weeks asking them to participate in the research (see Appendix 1b). With Danziger's (1979) experience in mind, I also enclosed in the package a revised information sheet about the project. In this I included a summary of my background and the fact that I had been married for many years to a GP and we had lived and worked in a rural area (see Appendix 1c). I also wrote two brief articles about the research project in the local GSDGP newsletter that was sent to all GPs in the region (See Appendix 2a). At the time of interview, all participants were given a consent form to sign where the right to withdraw at any time for no reason was stated (see Appendix 3). Prior to embarking on the main fieldwork in the GSDGP, I conducted a pilot study to test proposed interview questions for their effectiveness.

### ***Pilot project***

GPs and their spouses, all of whom had either lived or were living in a rural area, were chosen for the pilot project using a snowball technique that drew on existing contacts in my own network. Nine potential participants were contacted by phone, where I introduced myself, explained briefly what I wanted to discuss and asked for an appropriate time to call them to explain the project further. In the ensuing conversation, I gave a short summary of the research and invited them to participate in the project. All agreed to be involved. This number comprised four male and two female GPs including two OTDs, two female spouses and one male. A mutually convenient time and place were arranged to conduct an interview with each participant. This initial contact was followed up with a letter of introduction and information sheet about the project sent out prior to the interview.

Six participants lived in or around Perth and we met at a location of their choice, usually their home or office. One interview with a rural GP was conducted by phone and interviews with the two OTDs were held in the rural location in which they worked over 200 kilometres from Perth. After signing a consent form, all were interviewed separately except one female GP and her spouse whom I interviewed together at their request. Interviews lasted between 30 minutes and two hours and, where possible, were tape-recorded and transcribed. Given that the purpose of the pilot was to test interview questions, limited time was spent in participating in and observing the lives of GPs and their spouses.

I transcribed interviews and entered them into the qualitative analysis software analysis program, QSR N6, and coded the text for themes, ideas and patterns. Questions that elicited minimal information were either discarded or modified for future use. This process of evaluating the quality of questions in terms of the information they provided in the responses occurred as soon as possible after each interview. Questions were then rephrased if necessary, used for subsequent interviews and again re-evaluated. This process of assessment was ongoing whilst gathering data in the course of subsequent fieldwork with GPs and their spouses living and working in the GSDGP.

## **Data collection**

When I began fieldwork 60 GPs worked in the GSDGP and general practices were located in Albany, the large rural centre, medium rural centres large enough to support group practices and small rural centres offering the services of a solo GPs. Albany offered eight group practices and one solo practice. The majority of general practices outside Albany were located in areas designated as needing medical services. Six group practices were located in four medium rural centres with eight solo practices offering services in smaller, often more isolated communities. Some smaller locations were as close as 130 kilometres to Perth or Albany and others as far away as 530 kilometres. Solo GPs in small rural towns often practised out of a surgery in the main town and offered clinics at branch surgeries located elsewhere in the shire.

Forty five male and 15 female GPs worked in the Division (see Table 5). The majority of GPs interviewed were Australian trained with the largest group of non-Australian trained doctors being male GPs from South Africa.

**Table 5: Total number of GPs working in GSDGP and total number of GPs interviewed**

<b>General Practice</b>	<b>Male GPs</b>	<b>Female GPs</b>	<b>Total</b>	<b>Male GPs interviewed</b>	<b>Female GPs interviewed</b>	<b>Total</b>
<b>Large rural centre</b>	22	7	29	9	3	12
<b>Medium rural centre</b>	15	7	22	8	3	11
<b>Small rural centre (solo GP)</b>	8	1	9	8	1	9
<b>Total</b>	45	15	60	25	7	32
<b>Percentage</b>	75	25	100	55.5	46.6	53.3

Twenty five male GPs (55.5 per cent) working in the GSDGP agreed to participate, with ages ranging from early 30s to early 70s. Nine worked in practices in Albany, eight were members of group practices in medium-sized rural towns and eight were solo GPs in smaller rural centres. Most worked full-time (see Table 6):

**Table 6: Demographics of male GP participants**

<b>Age</b>	<b>Full-time work</b>	<b>Part-time work</b>	<b>Practice in large rural centre</b>	<b>Practice in medium rural centre</b>	<b>Solo practice in small rural centre</b>
<b>30s</b>	4	1	3	1	1
<b>40s</b>	6	1	1	3	3
<b>50s</b>	9	0	5	2	2
<b>60s</b>	3	0	0	2	1
<b>70s</b>	0	1	0	0	1
<b>Total</b>	22	3	9	8	8
<b>Percentage</b>	88	12	36	32	32

Twenty three male GPs (92 per cent) were married or in long term relationships and all except two had children (see Table 7):

**Table 7: Marital status of male GPs**

Age	Married or Partnered	Partnered with children	Currently divorced or widowed with children
30s	5	3	0
40s	8	8	0
50s	5	5	2
60s	4	4	0
70s	1	Not known	0
<b>Total</b>	23	20	2
<b>Percentage</b>	92	80	8

Seven of the 15 female GPs (46.6 per cent) working in the Division, agreed to be interviewed and ranged in age from early 30s to late 50s. Three worked in group practices in Albany, three in group practices in medium-sized rural centres and one worked as a solo GP in a small rural centre (see Table 8):

**Table 8: Demographics of female GP participants**

Age	Full-time work	Part-time work	Practice in large rural centre	Practice in medium rural centre	Solo practice in small rural centre	Partnered with children
30s	1	0	0	1	0	1
40s	3	1	3	0	1	3
50s	1	1	0	2	0	2
<b>Total</b>	5	2	3	3	1	6
<b>Percentage</b>	71.4	28.5	42.8	42.8	14.2	85.7

All female GPs were married or in long-term relationships. Three had adult children, three had young, or school-age children and one had no children (see Table 9):

**Table 9: Marital status of female GPs**

Age	Married or Partnered	Partnered with children	Currently divorced or widowed with children
30s	1	1	0
40s	4	3	0
50s	2	2	0
60s	0	0	0
70s	0	0	0
<b>Total</b>	7	6	0
<b>Percentage</b>	100	86	0

Overseas trained doctors were predominantly located in 10 of the 14 rural locations outside Albany (see Table 10). Fourteen OTDs comprising 12 male and two female were interviewed.

**Table 10 Location of OTD participants**

<b>General practice location</b>	<b>Male OTD</b>	<b>Female OTD</b>	<b>Total</b>
<b>Large rural</b>	0	1	1
<b>Medium rural</b>	6	1	7
<b>Small rural (solo GP)</b>	6	0	6
<b>Total</b>	12	2	14
<b>Percentage of total number of GPs</b>	16.6	13.3	23.3

The majority of this group of GPs had trained in, and originated from, South Africa followed by Britain. GPs also arrived from other countries in Africa, Europe, and Asia. One GP worked in a group practice in Albany, seven in medium-sized rural centres supporting group practices and six worked as solo GPs in small rural centres. The majority of these locations had been designated as areas of unmet need in relation to medical services. Most GPs had worked in a rural area in their country of origin or training (see Table 11):

**Table 11: Overseas trained doctors: length of time in rural general practice**

<b>OTDs in rural medical practice</b>	<b>0-12 months</b>	<b>1-2 yrs</b>	<b>2-5 yrs</b>	<b>5-15 yrs</b>	<b>Total</b>	<b>%</b>
<b>Current rural location in WA</b>	4	3	5	2	14	100
<b>Prior rural location in Australia</b>	1	0	2	0	3	21.4
<b>Prior rural location elsewhere</b>	0	0	0	6	6	42.8

Eleven overseas trained GPs lived with their spouses, two saw their families at weekends who lived elsewhere and one GP had been married and was currently single. The spouse of one GP had returned to her country of origin with their child as there were no opportunities for her to work in her chosen profession.

Twenty one out of the 23 spouses contacted agreed to participate in the research. They ranged in age from early 30s to over 50 (see Table 12):

**Table 12: Location of spouses**

<b>Spouses</b>	<b>Large rural</b>	<b>Medium rural</b>	<b>Small rural</b>
<b>Age 30-39</b>	2	2	2
<b>Age 40-49</b>	4	3	2
<b>Age 50+</b>	2	4	0
<b>Total</b>	8	9	4
<b>Percentage</b>	38	43	19

Sixteen of those interviewed were female spouses of GPs who had already agreed to participate in the research including nine spouses of OTDs. Four were spouses whom I had met at the RMFN lunch prior to commencing fieldwork and one was an independent contact. In addition, spouses/partners of five of the seven female GPs interviewed, including both female OTDs, also agreed to participate. Of the male spouses, one had recently started full-time employment in his chosen profession having previously reversed roles with his wife, one worked part-time, one operated a business from home and two were looking for paid employment. One female spouse worked full-time outside the home, five worked part-time in various occupations and ten were not in paid employment (see Table 13). The majority of spouses had been trained as professionals:

**Table 13: Spouses' employment**

<b>Spouse</b>	<b>Full-time work</b>	<b>Part-time work</b>	<b>Not employed outside the home</b>
<b>Male</b>	1	2	2
<b>Female</b>	1	5	10
<b>Total</b>	2	7	12
<b>Percentage</b>	10 (total) 20 (male) 6 (female)	33 (total) 40 (male) 31 (female)	57 (total) 40 (male) 63 (female)

GPs who were interviewed had lived and worked in rural locations for varying periods of time ranging from one week to over 30 years with one GP practising medicine in the town he grew up in. Six of the 13 Australian trained male GPs had been practising in a rural area for over 20 years and only one for less than 2 years. The majority, including OTDs who had worked in rural areas in their countries of origin, intended to stay practising in rural Australia.

### ***Entering/leaving the field***

Information from the field was gathered in 2003 from a range of sources in a variety of contexts. To minimise bias and reflect the diversity of locations, I visited every general practice in the region covered by the GSDGP over a period of four months to invite GPs and their spouses to participate in the research. This involved travelling over 6000 kilometres by car to cover an area of 87 000 square kilometres. Overall, including the time taken on the pilot project, I spent more than five months in the field gathering information and beginning the analysis and interpretation of data. Living in the area for several months for the sole purpose of carrying out the research proved beneficial. It indicated to participants my commitment to remain in the area for the duration of the data gathering process, rather than make occasional visits from the city. It also offered flexibility to participants when I arranged interviews or attended social functions. At the beginning of fieldwork, making explicit my intention to remain in the area for several months to gather information also facilitated leaving the field-site once sufficient data had been gathered.

Sorting out my accommodation in the field turned out to be serendipitous in finding key informants who assisted in the process of contacting GPs. Jessica,<sup>27</sup> a friend of Lucy who worked at the Division, was someone I had never met before starting fieldwork. Lucy had initially suggested I stay with her whilst I was working in Albany but withdrew her offer at the last minute. Jessica stepped in and invited me to stay, asking me to house-sit for six weeks while she was on holiday. I agreed and Jessica subsequently became a key informant. She was familiar, with the location having lived and worked in the area for many years. She was employed in a health context and knew many of the GPs. She assisted in the process of accessing GPs by suggesting that practice managers (PM), not receptionists, were the gatekeepers. With this in mind, I decided that to be successful in meeting GPs and engaging them in the project was contingent on first building rapport with their PMs. Before Jessica left, she introduced me to one PM, Liz, who was interested in learning more about the project. Following

---

<sup>27</sup> All names of individuals are pseudonyms

our meeting, she introduced me to four GPs in the surgery in which she worked, all of whom agreed to be interviewed. I conducted my first interview that day.

However, I had enough personal experience to know that if you arrive at the surgery, are not introduced to the PM, are not a patient and expect to see the GP to arrange an interview, there is a high probability you will be rejected with the catchcry that the GP is 'far too busy' and is 'completely booked up', with not much recourse to return and try again. This reinforced my decision that building rapport with the practice manager was necessary to engage GPs in the research. In an excerpt from my field notes I made the following observations:

It seems that if I can actually get past the PM and talk, however briefly, to the GP I can usually persuade them to be interviewed. I go with whatever time the GP offers to give me for an interview. This can be five minutes which usually will extend to 20, to an hour and a half. One interview was spent travelling with a GP to the hospital, waiting in the corridor while he saw his patients in the ward, resuming the discussion while driving back in his car and then finishing off the interview while he ate his lunch in his surgery. ... The catchcry for me is 'be prepared' so I go everywhere clutching a copy of questions to ask, consent forms, a letter of endorsement from the Chair of the Division, not to mention information sheets as GPs have either forgotten what I sent or never read them or binned them. I also take a tape recorder, adapter, two cassette tapes, an extension lead and a pad and pen to take notes as a back up in case the recording fails. Just as well. I was introduced to one GP by the PM in between patients and the GP said he was free and I could interview him straight away, which I did (Excerpt from field notes July 2003).

Hammersley and Atkinson (1995) suggest that meeting and overcoming obstacles to gaining access offers the researcher insights into the social organisation of the setting. Practice managers as the gatekeepers of the GPs are the 'conduit' through which attempts to access the GP pass, so PMs are powerful. They 'protect' the doctors by filtering other people's demands on the GPs' time, including pharmaceutical representatives and researchers like myself, by prioritising their degree of importance. They attend to the smooth running of the practice on a daily basis and their responsibilities may include managing the staff, business and administrative aspects of the practice. Some also organise the GPs and humour them when necessary.

The majority of PMs were women although men held the position in the two biggest practices in town. My strategy was to arrive at the surgery, carrying my information package on the project and ask the receptionist for an appointment to see the practice manager. This was generally successful and I either saw the PM straight away or arranged an appointment. When I met him/her, I thanked them for seeing me sometimes making a positive comment about the surgery, helpful staff or even the weather to break the ice. I briefly explained who I was and what the project involved and asked for their help as to the best way to contact the GPs. I took time to build rapport, hoping they would be predisposed to presenting the project in a positive light to the GP. I discovered that, if rapport was established, PMs generally went out of their way to assist me. If not, they indicated that the GPs would not be interested in the research and signalled the end of our conversation. Sometimes, when I persisted, the PMs agreed to ask the GP though not always with successful outcomes. I ruminated on some of the reasons PMs responded differently and recorded my reflections in field notes:

The role of the practice manager as gate keeper is interesting particularly in the context of the social organisation of the practice. There is a difference in a PM being proactive and in a position to guide/advise GPs as opposed to being a glorified receptionist who lets the GP make the decisions. The key for the proactive PMs seems to be whether the PM feels the project is worthwhile and will benefit the GPs, which may influence how they present it to them. In this case, a proactive PM has more influence than a passive one who would probably respond to what the GP cues in terms of interruptions to GPs' 'real work' which is clinical practice. It also indicates the difference between a PM saying, 'let me introduce you to the GPs and you can ask them if they are interested' as they come out of their rooms, as opposed to 'I'll give the information to the GPs and call you' (Excerpt from field notes August 2003).

Contacting spouses in the hope of engaging them in the project proved more difficult than I had anticipated. My initial goal had been to send out information separately to GPs and spouses as a way to symbolise their separate identities and ensure the information reached both parties. However, I was unable to access personal addresses which were confidential and not on the Division's data base. As a result, information was addressed to both GP and spouse and

posted to the surgery address. In terms of social organisation, this gave GPs the power to act as gate-keeper and decide whether to pass on the information to their spouses. I am unsure whether all spouses received the information and none contacted me personally to ask to be involved.

An alternative approach was to ask GPs whom I interviewed for their spouse's contact details which was usually successful. However, this approach again placed the GP in the position of gate-keeper. All overseas trained GPs gave me details where I could contact their spouses, all of whom agreed to be interviewed. Most Australian trained GPs also gave me details although two GPs declined on the grounds that their partners were either not well or were very stressed. If GPs chose not to be involved in the project, then opportunities to contact their spouses were significantly reduced unless I happened to meet them in the course of fieldwork or someone, other than the GP, gave me their contact details.

Methods of gathering information included participant observation, semi-structured interviews, conversations with GPs and their spouses in social settings, informal discussions with other community members, health professionals, local government officials, and examination of archival materials such as government reports, historical documents and media articles.

### ***Participant observation***

An ethnographic approach refers to a set of methods where the researcher participates in and observes people's daily lives over an extended period of time, watching events, listening, asking questions and gathering any information that might help in understanding the focus of the research (Hammersley & Atkinson, 1995). Participant observation allows the researcher to see first-hand what occurs in a given context rather than rely on the observations of others (Altheide & Johnson, 1994). Given that, as a researcher, I might not know what information may be helpful, I accepted the parting words of a university colleague who reminded me that 'everything is data' including the rejections, the obstacles and the disappointments. While the researcher seeks to understand the participants' definition of their reality and the 'organising constructs of their world' (Burns, 1997: 310), he/she can also critically observe that reality in the light of a broader

social context. The dominant role of the GP in rural health care, reflecting their position of power in the organisation and delivery of services, is a case in point (see De Laine, 1997).

The hours spent sitting in surgeries waiting to interview GPs allowed me to observe interactions between GPs and their staff including the practice manager, the practice nurse and the receptionists that provided information about the social organisation of a rural general practice surgery. Sometimes, a GP invited me home to dinner where I noticed the setting, the interactions between family members, the division of labour and the meaning attributed by family members to the GP's work. This information offered a vignette of social organisation within a specific, non-professional context. I also participated in various social activities in different locations: attending functions at the local museum or art gallery, being invited to fund raising events or to dinner at the home of the GP and occasionally stopping to chat with GPs and their spouses at coffee shops or when walking along the beach. I struck up conversations with other local residents in various settings: wandering around local markets, attending agricultural shows and wine festivals, art gallery and museum openings or chatting to people in GPs' waiting rooms. When I explained the purpose of my research, people's responses often yielded rich information with some openly expressing their views on the role of GPs in rural health service delivery. Responses ranged from some believing GPs occupied privileged positions that subordinated those who also offered necessary services in rural locations to others believing rural GPs were close to sainthood and were entitled to whatever incentives they were offered.

Writing field notes constitutes a central focus of ethnography (Hammersley & Atkinson, 1995). As Emerson, Fretz and Shaw (1995) suggest, field notes provide documentation of observations, impressions, interpretations and experiences of people, settings and events. I also wrote down my reflections, 'ideas, fears, mistakes, confusions, breakthroughs and problems' (Spradley, 1979: 76) as a way to learn from my experiences and develop my understanding of the context in which I was working. For greater accuracy, I preferred to record my responses within 24 hours of an interaction or event while they were still fresh in my mind and I could remember details. Field notes also offered useful

descriptive information as well as important analytic leads. Recalling Emerson et al (1995), they helped identify my biases, prejudices and changing attitudes towards people and events that I experienced over time. To increase my motivation to record my field notes, I developed an enjoyable ritual following interviews with GPs and their spouses:

I have discovered all the good coffee shops in town where I go after interviews to chill out and write up my impressions, thoughts, ideas, and hunches about what happened, as well as taking in the view of the King George Sound while sipping delicious, freshly-roasted coffee. The coastline is so beautiful with views to die for from various locations in and around the town centre. Gathering information, especially organising and conducting interviews has been fun, sometimes. I have also felt challenged, despondent, excited, frustrated, rewarded and constantly on a steep learning curve. I've struggled with wondering whether I am getting the right data, enough data and finding the determination to pluck up courage to cross the threshold into yet another surgery to see if a GP is willing to participate in the project. I often feel a sense of surprise and relief when they agree to be interviewed. ...Of course there are others who are not interested and I eventually accept that. I use my contact with them or the gate keepers (PMs) to establish what worked in my interaction and what didn't. I try and use this information to inform how I approach the next surgery. Sometimes, though, insights elude me and I don't know and I assume they are just not interested and I move on (Excerpt from field notes August 2003).

### ***Interviews***

Semi-structured interviews were an important method of data collection. I tape-recorded and transcribed interviews with GPs and spouses subject to each participant's written consent. Interviews were an opportunity to gather detailed, descriptive material to contextualise participants' responses and elicit information on a range of areas. These included motivating factors influencing the decision of GPs and their spouses to live and work in a rural location such as a rural lifestyle or the opportunity to practise procedural medicine. GPs also faced challenges in the workplace as a result of health reforms, bureaucratic requirements in clinical practice and their professional relationship with others working in the health field. Spouses were often met with limited opportunities to find employment or engage in further education or training in a rural setting.

GPs and their spouses occupy positions of status and privilege in the social organisation of rural communities. GPs are powerful in that people seek their expert knowledge and skills and generally listen to their advice. Building rapport at the beginning of the interview and sustaining it throughout, particularly when interviewing members of a powerful social group, was something I considered essential to creating an environment for effective communication (see Encel, 1978; Feldman et al., 2003; Hammersley & Atkinson, 1995). With this in mind, I conducted the interview process whilst at the same time building rapport. I assured confidentiality in presenting the findings by reiterating that identifying factors such as names and specific locations of practice would be removed. I stated clearly the purpose of the interview was to discover and seek to understand participants' expectations and experiences of rural general practice while at the same time building rapport by being respectful, listening attentively and occasionally paraphrasing their responses to ensure I had understood the meaning. I noticed participants' non-verbal responses to questions that helped influence the direction of the interview. This approach allowed me to engage with participants by being sensitive to, and interested in, their responses and build an atmosphere of trust where they were encouraged to talk, reflect, discuss and explore the issue being addressed.

I had modified and developed questions in interviews with GPs and their spouses involved in the pilot project and used the revised version in interviews in the main project. Initial questions were designed to decrease any anxiety and create a relaxed atmosphere where participants felt comfortable. Questions in the body of the interview were open-ended and phrased to elicit as much relevant information as possible about factors affecting their lives and work practices in a rural location. A demographic profile of each participant was taken during the interview for future analysis to note similarities and differences between GPs and their spouses and the locations in which they lived and worked. I often referred to the set of prepared questions during the interview which assuaged my anxiety and gave me some control to guide the discussion in specific directions. However, not all questions on the interview schedule were asked in every interview. Time constraints and/or participants' responses that engaged more deeply with certain topics that warranted further reflection prevented this. As

rapport and trust developed, particularly with those interviewed more than once, communication became less guarded as participants expressed more openly their difficulties and challenges in a professional and personal context that allowed a deeper exploration of the complexity and nature of meanings and interpretations they attributed to events, expectations and experiences. I referred less to the prepared questions on occasions like these to give participants the opportunity to reflect more deeply on their experiences. As one GP commented, he had only ever previously discussed with his wife the price they had paid as a family for the demands placed on his role as a rural GP when it intersected with his role as a husband and father and on his own mental and emotional wellbeing.

General topics covered in the interviews included GPs' and spouses' expectations and experiences of rural general practice and its interface with the demands of home. More specifically questions for GPs revolved around the impact of recent health reforms on how rural GPs practise medicine including issues related to medical accountability and the threat of litigation. Other topics related to the increasing feminisation of the medical workforce, changing patient requirements, participants' level of involvement in community activities, links between GPs' work satisfaction and requirements for their leisure pursuits and their family's wellbeing, suggestions for innovative solutions for the future of rural health services and coping with personal and professional isolation. Questions for spouses covered their experiences as the spouse of a rural GP, their expectations of that role and their personal aspirations. For OTDs and their spouses, factors explored in interview questions included reasons they left their country of origin, cross-cultural challenges, expectations of life in rural Western Australia and social and professional support.

Interviews were conducted with 32 GPs and 21 spouses. Seven GPs and five spouses were interviewed more than once with one GP agreeing to a second and third interview. Interviews lasted from 20 minutes to three hours and were conducted at a time and place convenient for the participant. Interviews with GPs were often held at the surgery in their lunch breaks, in between patients or at home after the surgery had finished. Five were conducted in a cafe over lunch or coffee and cakes. Spouses' interviews were mainly held in their homes although they, too, occurred in cafes and two were conducted walking along the beach and

in the bush. Most were carried out separately with each participant unless they requested interviews together. The rationale behind conducting interviews separately was twofold. First, given the demands made on rural GPs, separate interviews offered more flexibility to arrange mutually convenient times and locations to meet either the GP or the spouse. Second, separate interviews also provided a context where any differences in experience, perception or expectations between a GP and spouse could be freely aired without being influenced by the response of the other. Those who requested interviews together included two GPs from the same practice, two GPs and their spouses, two female spouses and two female GPs.

### ***Informal discussions***

In order to situate the research in a broader context, I also held informal discussions with various community members including other health professionals and local government officials on their views on attracting and retaining more GPs as a way to solve the rural health problem. These included discussions with six HSM/DONs in different locations and six CEOs of rural shire councils. Sometimes we met socially or I contacted them directly by visiting their place of work and making an appointment to see them to explain my research and discuss their ideas about the role of GPs in rural health care. I was also interested in their thoughts about innovative solutions to the problem. These discussions were not tape-recorded though I generally made notes during or after the conversation.

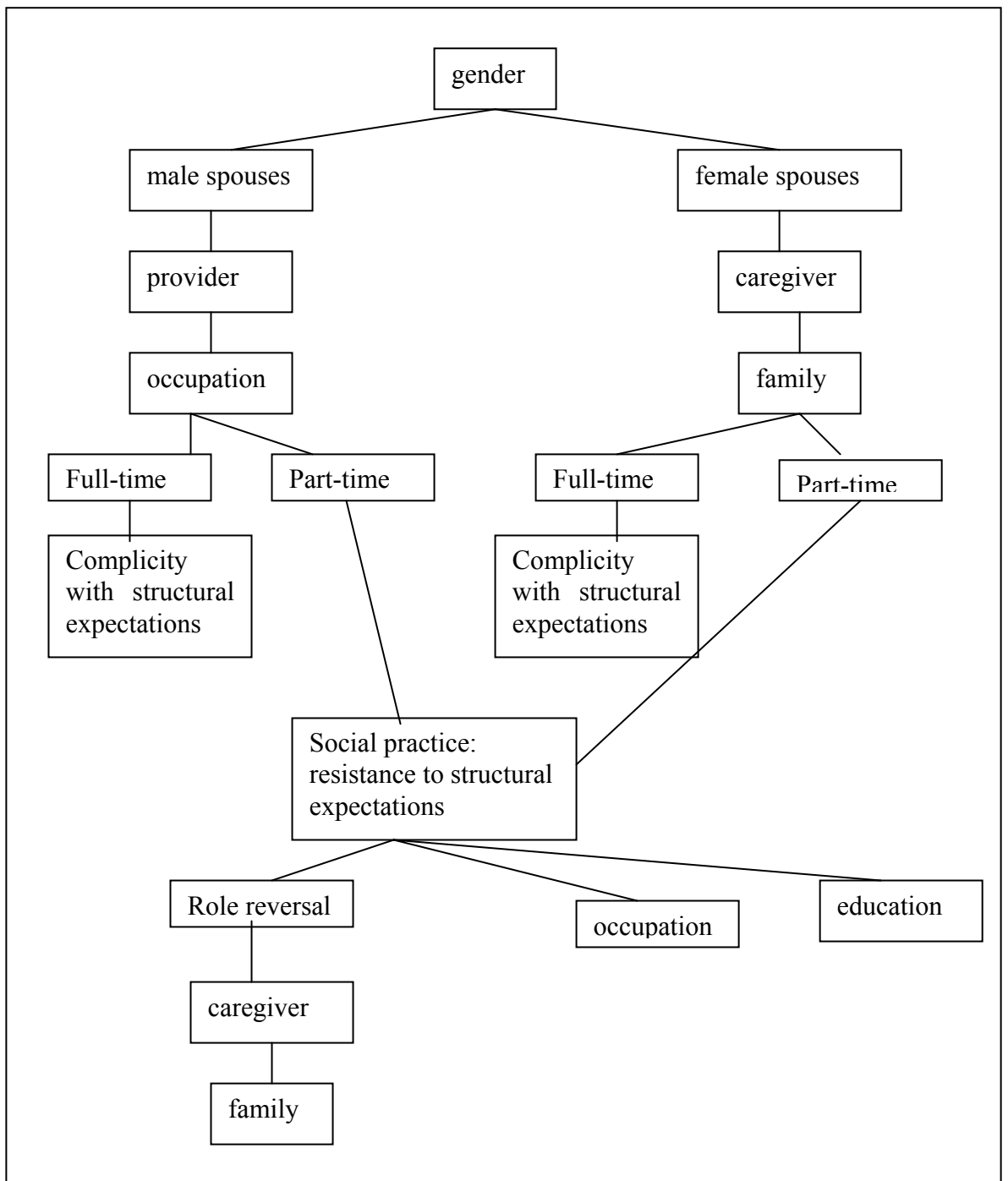
Discussions were also held with GPs and their spouses if we met socially. These were generally relaxed and informal though participants often brought the conversation around to discussing the research and made comments on their experiences and challenges. This was the case following an invitation to dinner from one OTD which was also attended by other friends of the GP and led to a discussion on challenges facing OTDs and their families living in rural locations. Some of the issues aired in discussions with participants and various community members were substantiated in archival material reporting on the state of the rural health service and the shortage of rural doctors.

### ***Archival material***

I searched various documents including oral histories of GPs who had worked in rural practice, historical records of various local settings I was visiting, media articles on rural general practice, government reports and local policy documents to help contextualise the research and supplement other information I was gathering. This information was accessed from rural shire council offices, local government departments, rural hospitals, local libraries, tourist offices and the internet. Some of these locations provided opportunities to meet people and discuss their thoughts and ideas about rural health and medical services. Newspaper articles were sourced from national and state daily newspapers and local community newspapers and newsletters.

### **Data analysis**

Information was analysed and interpreted in four stages. First I drew on Wolcott's ideas (2001) to describe the setting, events and key players involved in the project to provide a firm foundation on which to build the study. This became the backdrop against which ongoing analysis and interpretation evolved. Second, a preliminary analysis was conducted to reduce, organise and interpret raw data such as transcriptions, notes from interviews and field notes (Sarantakos, 1998). Transcriptions were imported into the qualitative analysis software package, QSR N6 which was used to collate and manage the data. Adopting an inductive approach, information was coded and categorised by sorting it into themes, ideas, concepts, hunches and patterns (see Strauss & Corbin, 1994; Wolcott, 2001) which were revised, modified, developed and refined as part of the ongoing analysis process. An index tree was used as a model in the N6 program to analyse, code and store data. Figure 1 gives a basic outline of the process showing the top level or dominant tree node representing a main theme under which are placed related themes or ideas coded from the data that are stored in various levels of sub-nodes from which emerge other sub nodes related to the dominant theme.



**Figure 1: Index tree: model of analysing and coding raw data into themes using Qualitative Solutions and Research (QSR) version N6**

For example, gender as an overarching theme might be organised into sub-themes such as the role of spouses of rural GPs who conform to structural expectations of gender relations with male as provider and female as primary caregiver. Another sub theme may represent resistance such expectations. This model illustrates how the analysis process develops and deepens. Specific themes or concepts are not mutually exclusive and may overlap with other themes. The work practices of female GPs may overlap with the division of labour in the home in rural medical marriages that could warrant a deeper enquiry into expectations of gender roles.

Themes, ideas and concepts were regularly reviewed, modified, developed, refined and summarised. Patterns in responses within and between groups, individuals and settings were identified and analysed for similarities and differences in the light of research questions. Conclusions began to form about how knowledge is constructed and shared, how power is organised. Understanding also developed of cultural meanings participants and different groups within the community attributed to the expectations and experiences of GPs and their spouses in rural locations. This iterative approach generates further questions to deepen the enquiry and seeks to understand and clarify deeper meanings that emerge from the analysis.

### ***Interpretation***

Third, echoing Wolcott (2001), the researcher's past experience, intuition and understanding help in interpreting the data. In other words, I used my cultural knowledge and experience of the lives of rural GPs and their spouses, and my sociological and anthropological background, to interrogate the information I had gathered in the field and set it against a backdrop of the research questions underpinning the project. This process allowed the data to be viewed from different perspectives so new meanings could emerge and lead to a deeper understanding of the relationship between structure and social practice. Theoretical perspectives also guided interpretation and further deepened my understanding of the data. Sorting, analysing and interpreting information effectively began on entering the field. I used field notes to record my thoughts, ideas, reflections, hunches, surprises and disappointments in response to events,

locations and interactions with participants and residents in different rural centres. This process provided early identification of emerging themes and patterns that were subsequently expanded, corrected, modified, summarised, and constantly revised as part of an iterative process.

Fourth, I critically analysed the ‘insider’s view’ (De Laine, 1997: 124) to more deeply examine the role of structural issues in social practice. Specific events and interactions within and between groups of participants were located in a wider social setting. This allowed the relationship between structural forces and social practice to emerge that revealed the organisation of power relations in a rural general practice context. This widened the lens with which to analyse the expectations and experiences of GPs and their spouses in the context of rural health service provision. Data could then be interpreted with a view to examining the dialectical relationship between broader structural issues and their impact on social practice. Drawing out ‘cultural assumptions in which biomedicine is grounded and the practices that sustain it’ (Lupton, 2000: 12), offered a deeper analysis of factors reproducing and contesting relationships of power. Tension experienced at the level of practice in the face of structural changes may reveal a struggle that can be examined more deeply for its potential to offer alternative solutions to the problem.

### ***Rigour***

Quantitative researchers expect reliability in findings if they are repeated by themselves or other researchers. This is not always possible in qualitative research. Studies of a particular group by one researcher in the field cannot necessarily be replicated as events that occurred in a natural setting at a specific time and the dynamics of relationships between participants and researcher cannot be reproduced (Burns, 1997). However, qualitative researchers see one aspect of reliability as recording data to reflect what actually happened in the field, enhanced by careful description and explanation of ‘physical, social and interpersonal contexts within which data are gathered’ (Burns, 1997: 323). A key component of ethnography is to see first-hand what occurs in a given context rather than asking others for, or relying on, their recollections or observations or interpretations (Altheide & Johnson, 1994). While we cannot assume the truth of

what participants tell us beyond reasonable doubt, dismissing their descriptions of thoughts, feelings and actions as having no face value is unwarranted (Hammersley & Atkinson, 1995). Ethnography rests on accurately representing as far as possible particular social phenomena that are revealed in participants' responses, actions and behaviour. This process assists in interpreting their meaning and function (see Atkinson & Hammersley, 1994; Hammersley, 1992). According to Altheide & Johnson (1994) methodological rigour is demonstrated through describing how the researcher presented herself to participants, gained access to organisations and individuals, built rapport and developed trust, responded to mistakes and surprises, and collected, recorded and interpreted information. I have attempted to meet these requirements when approaching this project.

## **Limitations**

Information gathered from GPs and their spouses for this project is localised to a specific rural area and does not offer a comparative analysis with GPs and spouses in other rural areas or metropolitan centres. A study of the clinical aspects of the doctor/patient encounter has not been researched.

The next four chapters will present the findings from information gathered for this ethnographic research project. Chapter 5 focuses specifically on the expectations and experiences of GPs trained in Australia.

## **CHAPTER 5**

### **Facing changes to work practices: expectations and experiences of Australian trained male rural GPs**

The hegemonic position GPs hold in the hierarchy of rural health professionals is symbolised by their autonomy, power and control over their work practices and those of other health professionals (Germov, 2003a). GPs' privileged status is also reflected in the esteem in which they are held in rural communities. However, social changes have caused tension in the relationship between rural GPs and the State as GPs cope with the effects of political and economic reform and changes in gender relations as increasing numbers of women enter the medical workforce. As rural GPs adjust to such changes, the question asked is whether their dominant position in rural health care delivery is being destabilised by events beyond their control? Currently, all rural GPs are faced with the significant role played by market forces in health care delivery. Cost cutting, increased government surveillance in clinical practice, calls for accountability from consumers and threats of medical litigation are common concerns in everyday practice often affecting work enjoyment. Studies show that many rural GPs in Australia are unhappy that governments are encroaching on their autonomy and control in the workplace and imposing increasing regulations that demand more accountability for their actions (Strasser et al., 1997; Wainer, 2002). Added to this, competition from other health professions to provide services is on the rise, larger corporations are buying medical practices, and growing numbers of women entering the profession are demanding a more flexible approach to working hours. In this climate, the ethos of rural general practice is changing; it is currently in a state of transition with many GPs feeling frustrated and uncertain about the future.

Despite these developments, many Australian trained, male rural GPs interviewed for this study continue to enjoy their work and plan to stay in a rural area. One reason for their choice is the opportunity to practise a variety of medical and procedural skills not available to most urban GPs. Findings also

reveal the hegemonic role played by the State in clinical practice. The State provides the economic framework in which health services operate. Health reforms and calls for greater accountability in clinical practice, such as encouraging GPs to practise evidence based medicine and become vocationally registered, have met with a mixed reaction. Evidence based medicine requires GPs use the best external clinical evidence currently available in conjunction with their own clinical knowledge and skills to make decisions about patient care (Australian Government Department of Health and Ageing, 2005: 593). GPs are required to undergo vocational training to provide them with necessary skills and knowledge to practise competently in the community. Vocationally registered GPs have been admitted to Fellowship of the Royal Australian College of General Practitioners (RACGP), which entitles them to access higher Medicare payments from the Health Insurance Commission for providing services. GPs are required to maintain their vocational registration through ongoing professional development in accordance with the Quality Assurance and Continuing Professional Development Program run by the RACGP (Australian Government Department of Health and Ageing, 2005: 604). Despite the benefits offered, not all GPs choose to become vocationally registered. Stated reasons for this include impending retirement or the fact that they are overseas trained and working on temporary resident visas in areas designated as needing medical services (Australian Government Department of Health and Ageing, 2005).

In response to increasing government intervention in clinical practice some rural GPs feel angry and uncertain about the future despite offers of financial remuneration as an incentive to adopt reforms. GPs who implement government regulations that expect more accountability from doctors provide a way for governments to place their clinical practice under scrutiny. Such reforms effectively reduce rural GPs' control over their work practices. The dialectical relationship between the State and the medical profession in a rural general practice setting is revealed in some Australian trained male GPs' angry responses to such structural constraints. However, others in this group view such reforms as inevitable in the current political and economic climate, believing that there is no alternative. They consider that, by working with the changes rather than against them, they and the general practice in which they work could benefit financially.

Despite the reforms, many male rural GPs continue to work long hours although the image of the heroic, rural male GP is coming under pressure.

A dialectical relationship between structure and social practice is also revealed in the context of gender relations in rural general practice. Some Australian trained male rural GPs are becoming increasingly reflective and are resisting this 'heroic' image in the face of social changes. They are proactively initiating changes to work practices by reducing their hours in order to achieve a better balance between work and home. This shift supports Pringle's (1998) idea that a major change in work ethic is already happening in medical work settings. Research from Britain suggests a ripple effect is occurring where growing numbers of male GPs of all ages are resisting conventional stereotypes of long working hours, instead seeking a lifestyle that is more balanced with room for greater flexibility in work arrangements (Young et al., 2001). However not all rural GPs are so receptive. Tension is evident in some rural male GPs' responses as their female colleagues adopt a different approach to work practices from the 'norm'.

This chapter identifies the dialectical relationship between structure and social practice by examining the expectations and experiences of Australian trained, rural, male GPs in the face of changes to gender relations and the political and economic climate. First, it identifies their responses to growing numbers of women entering the medical workforce. It then examines the effect of political and economic changes at the level of social practice. Australian trained male rural GPs discuss how they manage the tension in the face of structural requirements that often cause stress in the workplace and in the home. This perspective offers a more nuanced analysis of issues influencing the decisions of GPs to stay living and working in a rural location.

### **Feminisation of the medical workforce**

Drawing on ethnographic findings, responses indicated that female medical practitioners sought to balance work and family time. The majority of Australian trained, male rural GPs who worked long hours held conventional views of the division of labour and assumed women GPs would adopt the role of main caregiver in the home:

A few female GPs are full-time but they make a certain sacrifice to do that by not having children. It is children who really create the problem for female doctors. So for every child [a female GP has] there is a good 18 months [off work]. It is difficult to work when the child is little and some of them will drift off and come back later. You could lose them for years depending on what their values are and what they think is important (AMGP6).

There is an implicit assumption in this response that it is the woman who is the primary caregiver. Most male and female GPs are married or in committed relationships (Lippert & Tolhurst, 2001; Pringle, 1998). Male rural GPs often argued that the nature of rural general practice involved long working hours even though some of their male colleagues chose to work less to achieve a more balanced lifestyle. Their expectations that female rural GPs conform to conventional work practices and take responsibility for childcare and domestic tasks in locations with limited childcare services are not sustainable. Women who worked fewer hours effectively challenged the heroic approach to rural general practice. Nonetheless, hegemonic ideas of work practices were reproduced as male rural GPs were often concerned that their female colleagues ‘would not want to work as hard as we do’ (AMGP1) which would ‘significantly impact’ (AMGP5) on how rural medicine is practised. One GP commented wryly that the brunt of the workload would fall to male GPs when female GPs went home:

So the government will flog the ten male doctors to death quite happily. So will the other women (AMGP5).

In this instance, female GPs were held responsible for increasing the workload of their male colleagues, rather than the organisational structure of rural general practice that makes it difficult for women to meet the demands of home and work.

While different approaches to work practices caused tension in the ranks, other Australian trained male GPs supported the trend towards working fewer hours. One GP suggested that such a move was conducive to ‘self preservation’ where anti-social hours were no longer tolerated. He commented that there had been a ‘cultural shift’ in rural general practice where ‘there is a lot more

awareness about what is necessary to function well, and a lot more political lobbying' (AMGP12). Another GP agreed, commenting that:

Younger doctors are saying they want a life beyond medicine which is what I was saying 20 years ago and I was told to get lost. It didn't happen (AMGP10).

One older GP, reflecting on younger male GPs supporting such changes to work practices, mused:

They have probably got their priorities right. It depends on what your ambition is. My ambition was to build up a capital base for retirement because I had never had any money so there was an inclination to work harder and then send children away to boarding school and work even harder (AMGP6).

Nonetheless, for flexible working hours to become the norm, reassessing the organisational structure of rural general practice is necessary and rural GPs who chose to work less would have to be prepared to take a cut in their salary:

One of the crucial differences I have noticed in young doctors ... is that they have been told by the college how much they work so they all feel very 'precious'. They need to realise that if they don't work they are not going to get the money. The problem arises when they don't want to work but still want the same amount of money. That becomes a real problem (AMGP1).

The variety of responses suggests that tension exists amongst some male rural GPs in the face of structural requirements which they feel conflict with their interests and ideas about rural general practice. In other words, the dialectical relationship between structure and social practice is evident as some GPs struggle to reproduce hegemonic ideas of rural general practice in the face of increasing numbers of women in the medical workforce. Tension is evident as many women GPs contest dominant ideas about rural general practice and open the door to allow new ideas and work practices to emerge. As a result change is occurring with some male GPs supporting the changes. In this light, appropriate workforce planning becomes an important issue to ensure adequate health services are provided in rural locations. Other structural factors are also affecting the expectations and experiences of Australian trained, rural male GPs.

## Effects of health reforms on rural GPs' work practices

### *The bureaucratic gaze*

Increasing government control in clinical practice is undermining the power and autonomy of the medical profession. Power has shifted away from the doctors exercising authority over their work practices and towards government support of neoliberalist principles governing health policy. This has resulted in, among other things, calls for the medical profession to be more accountable for its practices. The dialectical relationship between structural changes and social practice is evident in the frustration many rural GPs feel at the State's unwelcome intrusion into what they consider as their territory. According to one GP, the fear of change has led GPs to 'drag each other kicking and screaming into the 21st century' (AMGP1). GPs reflect the tension in their relationship with the State, with some GPs commenting explicitly that their autonomy and control is being undermined:

Government control is definitely affecting GP autonomy. ... There is increasing government encroachment and it seems uncertain as to what it is they exactly want. It all revolves around money, not health care. They don't really care about the health of the people I see. That is the impression. They are more worried about the money (AMGP5).

Other responses suggest that government control is weakening the institutional power of the medical profession through constraints on clinical practice under the banner of maintaining standards and quality control in service delivery:

I don't have a problem with quality control. It is important to have quality assurance and quality control. ... Every doctor needs to ... spend significant time updating their knowledge and skill. ... My perception, probably shared by many of my colleagues, is that other parts of [government] regulation are red tape that give the government more control over the system. ... The trend is towards tighter government control. Some of the things we have been seeing in the Medicare system are that things are getting more regulated rather than less regulated. My suspicion of this is the government agenda of cost containment which is their high priority (AMGP2).

Indeed, implementing reforms involving increased accountability from the medical profession has often met with opposition. White (2000a: 292) argues

that many GPs resisted the introduction of vocational registration which was seen as a method of government surveillance of medical work practices that undermined doctors' control. Nonetheless, the State retained its control and gained the consent of GPs to such reforms by instituting penalties for non-compliance that deprived GPs of financial rewards. Financial incentives, such as PIP payments, are offered as a motivating factor to comply with health reforms, with negative consequences for non-compliance:

Accreditation [of a general practice] is tied in now to the remuneration package. If you are not accredited there are certain parts of the Medicare benefits which you can't access ... So again this is an area where further control has come in. I think accreditation is a good thing. I am all for quality assurance activities...But again the government has managed to [exercise its control] where there is a financial penalty if you don't comply (AMGP2).

GPs who are not vocationally registered are prevented from claiming a higher scheduled fee from Medicare for their services. Currently 77.7 per cent of GPs throughout Australia working full-time are vocationally registered, most of whom practise in metropolitan centres (Australian Government Department of Health and Ageing, 2005: 103, 115).

The interface between neoliberalist principles and clinical practice has caused disquiet:

The concerns of the marketplace are invading doctors' work to the extent that it does affect how they handle their patients. They over-service their patients in order to increase their income and write repeat prescriptions so the patient has to come back. Bad medicine but good business. ... There should not be a business side. We should be insulated from the concerns of the marketplace. ...The concerns of the marketplace should not intrude on our motives [for practising medicine] (AMGP9).

Another GP also reflected his anxiety in this context commenting that 'GPs don't get any training at all in the business side of running a practice' (AMGP6). His response is not unique given that some of the larger general practices now employ a business manager, a service often not economically feasible for smaller practices.

Responses from many male GPs expressed that increased government intervention had diminished their enjoyment of general practice, not least because they felt coerced into meeting bureaucratic regulations:

There are so many requirements that you can't just treat diabetes. You have to do a diabetes care plan whether people want it or not. You don't really have to, I suppose, but then they won't pay you. There is control and manipulation (AMGP5).

Some were outraged at the reforms, with one solo GP saying that government control 'decimated my enjoyment of general practice and my pride' (AMGP11), while others just felt disillusioned at their loss of autonomy in clinical practice (AMGP5, AMGP4, AMGP11). They felt disempowered and frustrated as they sought to meet government regulations and submit claims to access financial incentives. This process generally incurred extra time and costs over and above their clinical work that were not remunerated:

It takes hours to work out what you can claim ... within the HIC system. We are actually having to pay people to get all the bureaucracy under control (AMGP6).

Tension in the relationship between the State and rural GP is evident in the sense of irritation GPs feel as the administrative burden of many work practices has increased to comply with government regulations:

The big complaint is that people spend so much time proving they are [practising good medicine] that they don't have time to [practise] it because so much time is taken up in the paperwork. ... It is frustrating and irritating because it is time away from doing what you want to do which is clinical work (AMGP9).

The dialectical relationship between structure and social practice is evident in those GPs who withstood the tension and chose to accept government health reforms. They made the decision to work with, rather than against structural elements by adapting to the current political and economic climate in a way that best served their interests and those of the general practice in which they worked. There was a sense that resisting government reforms was pointless and counter-productive:

Our experience is that resisting change is futile because there is someone very high up in Canberra and the State Health Department who has a plan and they will implement that plan because, at the end of it all, they believe they will control the health budget. Because of the futility of resisting, we think it is better to implement the system if you think it is worthwhile. ... One of the things we believe is that, unless you stay close to the government, you have no idea what is going to happen. If you stand and stone wall, it is not going to change the government unless you are a particularly powerful lobby group and GPs aren't because they have multiple representatives and no two GPs will agree on anything much (AMGP6).

This response illustrated the hegemonic position of the State and was supported by comments such as 'there is no point resisting them' (AMGP7) although this GP conceded that:

Once we move into total bulk billing and PIP (Practice Incentives Program) payments and whatever else you can get hold of, you may as well be working for the government. You have lost your autonomy. This is what the government wants us to do (AMGP7).

These comments suggest a gradual, but systematic, erosion by the State of the traditional power base of the medical profession that is undermining doctors' control over their work practices. Nonetheless, demands for accountability were not considered unreasonable in that people have a right to expect quality of care. One GP thought more research was necessary on the link between cost and health outcomes:

I don't have a problem with accreditation and ongoing CME but I think there needs to be a careful balance. There is a danger as the government is quite quick to link those positive reforms to regulations and cost containment. In their defence, they say, 'we are spending all this money, what are we getting for this money?' There hasn't been good data about outcomes; even now that all this money [has been spent] on doctors and GPs, does it actually improve the health of Australians? [The government] is on an agenda to at least get evidence, 'best practice' that [they] are spending all this dough and want to actually see that it makes a difference. I think that is reasonable (AMGP2).

Such comments reveal that the interests of the medical profession and the State may conflict, yet the tension generated as a result of this struggle has the

potential to lead to change. At one level the comments illustrate how the State creates a consensus around the centrality of a neoliberalist agenda in government health reforms where health outcomes are achieved by cost effective practices. Such reforms calling for accountability may indeed diminish the autonomy and control of rural GPs over their work environment and highlight the hegemonic position of the State in its relationship with the medical profession. However, the above GP also reflects on the need for accountability within the medical profession to ensure, not only value for money, but also the motivation to provide quality care for patients. Other reforms were also affecting the social practice of rural GPs.

### ***Competition***

Neoliberalist principles underpinning health reforms that encourage competition for services have also affected GPs, their fee structure and negotiation of work contracts with local hospitals. Competition is another 'site' where the hegemonic power of the State influences the terms and conditions of rural GPs' work practices:

The government has been pushing competition. We have an ACCC (Australian Competition and Consumer Commission) which safeguards competition. Doctors have been on the receiving end and have to be very careful about the fees they set. ... Until recently the ACCC said you shall not set a fee across a surgery. Every doctor must set their own fee. If you do [set a standard fee] that is deemed as colluding and engaging in anti-competitive behaviour (AMGP2).

The same GP expanded on this theme in the context of work contracts between rural GPs and the local hospital:

[The local hospital] finally got its act into gear. When it came to signing, we had the right to negotiate the contract as individuals but not as a group because the ACCC would come down on us. So we don't really have a lot of power in this respect. ... We were forced to sign [the contract] because we weren't in a position of power to negotiate [as a group]. If I say 'I'll pull out, I am not interested in this contract', the hospital still had all the other GPs. ... There is competition but it was an example of the way those competition laws worked in favour of the government (AMGP2).

Whilst the relationship between the GP and hospital management was sometimes conflictual, it was often expressed as a clash of personalities. In reality, the relational conflict illustrated the interests of different institutions and suggests a clash of 'systems' within the organisational structure of health service delivery. The hospital as an institution of the state of Western Australia is required to operate within budget constraints and gain maximum efficiency and cost containment in service delivery while providing 'best practice'. The rural GP as private practitioner, whilst being required to provide quality care for patients may be restricted by limited resources at a state level. The GP also wants control over his/her work practices and the opportunity to maximise income potential with minimal bureaucratic interference.

Increasing competition for services from non-medical health professionals is also challenging the hegemonic status of the medical profession in rural health care delivery. Registered nurses and Aboriginal health workers offer a restricted range of health care services in some rural centres which, in a metropolitan centre, would be provided by GPs (Strong et al., 1998). The issue of whether all rural locations need a GP received short shrift in some GPs' responses. Instead a one-size fits all approach prevailed:

Why shouldn't [rural locations] have [a GP]? It's about equal access. Why should a community not be entitled to a doctor? The government talks about equal access to everything but it is lip service only (AMGP10).

This view clearly reflects the hegemony of the medical practitioners in relation to other health professionals who were often seen as second best. One older GP supported this view by diminishing the skills and knowledge base of nurses, claiming that 'outside of stitching a few little cuts, they have no medical knowledge' (AMGP11) with some 'rare exceptions'. He went on to argue that:

They are trained well as nurses. ... If they are going to do the work of doctors they need to be trained as doctors. ... Nurses can dish out [advice for] simple little coughs and colds and then send [patients] to see a doctor (AMGP11).

However, other GPs were willing to extend the rural health care debate beyond a medico-centric focus by consenting to nurse practitioners providing

services in localities unable to attract a GP. When asked whether there were other areas in medical practice where role sharing could occur one GP commented:

Nurses are the unsung heroes. ... [Role sharing] has got its place, for sure. It is important not to have a doctor-centric focus. The good doctor doesn't necessarily know it all. ... The skills nurses contribute to practice in remote areas are just as valuable as those brought to those areas by doctors. If you start filling remote areas with clinical nurse practitioners and consultants as a strategy in lieu of doctors, well, if that has to be done, it has to be done. It is better to have nursing staff who are well equipped and well skilled than no-one at all (AMGP12).

According to another GP, the idea of role sharing with other health professionals was 'inevitable' (AMGP4) in rural centres unable to attract GPs as long as there was adequate medical back-up. His acceptance was conditional, however, on nurses not taking away the work of doctors, again reinforcing the hegemonic role of the medical profession in health service delivery. One GP, while supporting the idea of role sharing, thought that problems of adequate staffing and cost containment would still persist:

What I see a nurse practitioner doing is living in the community and offering a service. But they are going to run into the same problem as the GP. Are they going to be available 24/7? What about back-up? It is just an extension of the same problem. They are not going to be cheap to employ, not much different from a doctor because of the hours they work and everything else. You could argue that they might have less skills than a GP. But it depends on what the GP has done. They might have just sat in a chair and consulted. And a nurse is quite capable of doing that (AMGP6).

Another GP commented that governments 'will never solve the problem' of recruiting GPs to work in smaller rural centres because GPs 'don't have any freedom' and are 'forever on-call' (AMGP7). The same GP mused on the difficulties of professional and social boundaries being blurred as:

...friendships and [work] get blended in a rural community. You would never be able to relax and put your feet up and have a few beers...The only solution is to have a nurse practitioner (AMGP7).

While some GPs vehemently resist challenges to the dominance of the doctor's role in health services, others are open to change and considering the role of nurse practitioners as a possibility. However, most considered using nurse practitioners only in areas unable to attract a GP. One issue for whoever provides health services in a rural setting is indemnity as the prevailing social climate becomes more litigious. With the medical profession being held increasingly accountable for its actions, threats of litigation in relation to medical mal-practice are on the rise.

### ***Indemnity***

The issue of indemnity in relation to clinical practice was of particular concern to some procedural rural GPs:

What worries us is where do we stop having to worry about the stuff we have done in the past? If you are working somewhere, your liability stops at the time you are working in that place. Our liability goes on for 25 years after we have delivered the last baby. So, if they are going to start having a go at me, I need to be in reasonable nick otherwise I will be in my 80s. I need to keep paying [medical] insurance policies for the next 25 years in case [I] get sued (AMGP7).

Some rural GPs had stopped doing procedural work in the area of surgery and obstetrics to offset the costs of medical insurance and minimise the threat of being sued. Others lived with the threat and remained passionate about the satisfaction they gained from the procedural aspect of rural general practice. One GP commented that he 'enjoyed every day in rural general practice' and to give up procedural work and 'just be a GP, would kill me' (AMGP7). Another said if he reached the stage when he was 'just pen pushing,' he would 'stop general practice altogether' (AMGP1). Many commented on their sense of pride in being a rural GP and delivering a good service to their patients from which they derived enormous satisfaction:

I think I can provide a very good service. I can help people. I am very happy I can do that. I am sure my patients are very happy I can do that also (AMGP1).

While quality of care was an issue for all doctors, rural GPs expressed their concern at how medico-legal issues affected their work practice at an

individual level. The threat of litigation was stressful and often led many GPs to practise 'defensive medicine' (AMGP4). One GP, with two cases pending of threats to sue him, commented that, while he ordered more investigations when diagnosing and treating a patient to legally protect himself, the risk of being sued was still a 'stress' (AMGP8). Another GP revealed the effects on his work practice of the developing trend in medical litigation:

I would only do something if I felt I could competently do it. ... I'm a bit more concerned if a claim ever comes up against me because I don't feel anywhere near as secure as I did before because I now have a very dodgy agreement with the state government, ... and I have an insurance policy which is only good for one year, to be renewed every year. So my security is much less than it was. ... I feel less secure about my indemnity to the point where I have to consider who owns what in my family because of the way the law works. It comes at you from all angles, and, if you work for so and so, they will probably sue them as well. It is quite tedious, very complex and way beyond us (AMGP6).

The sense of insecurity generated by medico-legal issues that pervade rural general practice raises the question of how rural GPs cope with the stress of work. Research findings show that chronic occupational stress is 'likely to reduce the quality of life and increase risks of negative health and mental health outcomes' (Winefield, 2003: 198). How does this group of rural GPs deal with the stress of structural reforms impacting on work practices in a rural setting?

### **Collegial support for rural GPs**

Responses suggest that rural GPs do not feel supported by their urban colleagues who 'would have no idea of the conditions we work under' (AMGP5). Instead, a disunity within the medical profession is evident where disparate groups, such as specialists, were seen to look after their own needs rather than support other medical colleagues including GPs. One rural GP suggested that different specialist groups were unified and powerful which contributed to their success in negotiating with government to meet the terms and conditions of their work (AMGP2). He commented that, as a group, GPs were 'notoriously individualistic' and divided which diminished their negotiating power politically. Another suggested that 23 000 GPs in Australia should

constitute a political force (AMGP5) particularly as several felt their grievances were not adequately represented. One GP added, somewhat despondently, that 'no one listens to GPs. We just have no say. There is nothing we can do' (AMGP3).

The division within the profession is mirrored in the various organisations representing the interests of rural GPs including the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA), the Rural Doctors Association of Australia (RDAA), the Australian Centre for Rural and Remote Medicine (ACRRM), all of whom 'vie for legitimacy' (AMGP2) and offer a 'fractured representation' (AMGP2) with each organisation meeting their own agenda. This often left rural GPs feeling their concerns were inadequately supported. One GP resolved this issue by leaving the AMA who were 'no bloody help at all' (AMGP7). The only place he felt his concerns were heard was at work. Medical colleagues in his practice offered him support and understanding. Such a response is particularly welcome in light of the lack of support experienced by many rural GPs from larger medical organisations. Such support is timely when rural GPs are coming to terms with political and economic reforms that are undermining their sense of autonomy and control over their work and affecting their enjoyment of clinical practice. This is on top of a job requiring a level of responsibility that some already find stressful.

### **Stress and rural medical culture**

Some GPs commented on the stress of responsibility that accompanies their hegemonic position in relation to other health professionals in the delivery of rural services:

We are taught that the buck stops with us. We are not team players at all. ... It is up to you. You have to act. ... You don't need to debrief. You are taking responsibility. You are going to get the kudos, you're going to get the shit. The buck stops at you. If you are a certain personality you can accept it, otherwise you will go and become a part-time city GP where, any time there is a potential problem, you write a referral to somebody (AMGP10).

This sense of responsibility increases in a climate of medical accountability where the threat of litigation for rural GPs' is often greater if they, rather than

specialists, undertake procedural work such as obstetrics. However, any negative effect of such expectations is further compounded by a medical culture that falls short of coping well with doctors' experiencing stress. Any institutional ethos of caring for colleagues in need of support from other medical practitioners is often absent (a'Brook, 1990; McKevitt & Morgan, 1997; Sexton, 2002). The inability to cope is considered an unsuitable trait in the medical profession where illness is seen as acceptable for the patient but inappropriate for the doctor and therefore it is often resisted or denied. The doctor as patient is considered an anomaly (McKevitt & Morgan, 1997). One older GP found a way to cope with stress as a young doctor was to work less. This choice was unacceptable to his medical colleagues from whom he received little support:

Most of my peers said if you are not going to [pull your weight], get out of town, you shouldn't be doing medicine as a man (AMGP10).

Attitudes where the doctor as patient was seen as an anomaly were not uncommon in practice. Regarding the stress of work, one older GP enthusiastically commented:

I love the stress. The more stressed you are the more excited you are, the more involved you are, the more proud you feel when you have done something that you know is difficult (AMGP11).

Another response was more tempered but nevertheless reflected the need to carry on working despite being ill:

You don't let your colleagues down. You soldier on. We don't see anything abnormal or unusual about that. No doctor here has ever committed suicide (AMGP9).

However, for GPs who had persisted in working despite increasing stress, serious implications ensued:

I just got more and more stressed. I didn't know I wasn't managing. I just one day said I am not doing this any more and left town (AMGP5).

Given the constraints within medical culture of doctors' coping appropriately with stress, one GP's dubious solution to the stress of overwork

was to work more: 'working is a relief from stress' even though, in his professional environment, he felt 'hounded, persecuted and harassed' (AMGP13) by the government. This affected his sense of wellbeing and had a detrimental effect on his relationships with other health professionals. When asked whether he was concerned about the effects of stress on his health, he responded: 'I haven't burnt out. I just carry on'. The experience of burn-out in another GP, who took several months off work, led him to reflect on the implications of not managing stress effectively:

I didn't go to the doctor and say "I'm burnt out". Everyone could see I was burnt out. Nobody told me I was burnt out. My patients kept saying "you look after yourself." Eventually, for lots of reasons, I got too tired. I forgot to smile but I still had the insight to leave and go away for six months but I still didn't seek help. I was quite unwell. It took me about four weeks to just stop pacing (AMGP6).

A disturbing aspect of this experience was the lack of attention given to this GP by medical colleagues who either did not see, or did not respond to his stress. When asked about their responses, he commented:

Nothing. I don't think they were ever aware. I don't know. I don't understand it. I know there was another doctor in town who got depressed and he said everybody just watched him (AMGP6).

On further reflection, he justified the lack of attention paid by medical colleagues in his own practice:

Within your own practice you don't see that much of each other. We do have meetings once a week but we never discussed that sort of thing. It's a male ego thing, isn't it? It is not really a culture of caring for each other. Having cared for [patients] you tend to just stop. Enough. You are at a meeting and it is relaxing and you are not analysing each other. I don't know whether we all put on facades. I don't know. I have thought about it a lot. It is interesting how, within a practice, no one can see [if another doctor is experiencing difficulty] (AMGP6).

Health professionals and staff working within a general practice may also choose to ignore the fact a GP may be experiencing difficulties given the his dominant

position in organisational structure of the health care hierarchy, further isolating the GP:

You're the boss, the doctor, the top of the hierarchy and nobody tells the boss what they can see (AMGP6).

Factors contributing to stress within rural general practice are being increasingly recognised with calls for a balance between work and home particularly from female medical practitioners. According to one GP, a generation ago a GP's 'whole life was medicine' (AMGP10). Now, younger GPs are more aware of the need for 'self-preservation' by having 'less tolerance of horrible on-call hours' (AMGP12) and more emphasis on 'self-care' (AMGP3) reinforcing the notion that medicine is becoming more of a job than a vocation. One younger GP commented:

We tend to look after ourselves better. ... There has been a cultural shift. There is a lot more awareness about what is necessary to function well (AMGP12).

One important area that can contribute to a sense of wellbeing is that of personal relationships.

## **Personal relationships**

The life of a rural GP who works long hours would be difficult without the support of a spouse/partner. A survey in South Australia found that 45 per cent of rural GPs have virtually no other person, other than their spouse, with whom they feel comfortable discussing personal or professional problems. For those who are in crisis and reluctant to seek help, having a trusted confidante is considered essential for their emotional wellbeing (Sexton, 2002). However, the demands of a rural GPs' work often placed great stress on the spousal relationship:

I think it is very difficult for doctors to sustain relationships, or meaningful functional ones. For starters, they are not there a lot of the time and when they are there they are often stressed over other things (AMGP5).

These sentiments were supported by another male GP who ruefully commented on how he managed the demands of work and family:

I haven't managed them very well. General practice takes over without you even realising it. ... That encroaches on your life at home because you get grumpy and tired. ... Most partnerships last really well. We were talking at a party about whether my wife ever got angry with me. She didn't get really angry with me. She was disappointed with me not coming home, having her conversation with me interrupted by the telephone call from the hospital, disappointed because I was so tired having been up all night and come home for breakfast and go to work and there was no time to chat. So there is this constant strain in your partnership. ... My wife also felt a little powerless because I am not always inclined to take her advice. There is always a tendency to go beyond the point where you fail to see the obvious and fail to take advice (AMGP6).

In a study on doctors' wives in Florida, Nelson (1978: 586) quotes Harrison's findings where the work ethic of doctors is seen as a 'demanding mistress who always wins'. This theme is reflected in the comments of one GP who expressed the tension of juggling the demands of home and work where general practice effectively becomes 'your second marriage' which is 'always a problem':

How do you blend it? I don't know. You usually find you try to keep the working marriage working, because if that falls apart you are in big trouble. ... You try to keep that one working and you try to do the best you can at home (laughs). Sometimes it gets a bit dicey (AMGP7).

When children are involved, there is often even less time together as a couple (AMGP8) and, according to an older male GP, 'you have to have a very special woman' (AMGP11) to withstand the demands of being in a committed relationship with a rural GP. Marriages or committed relationships generally fell within traditional gender lines with the male GP as provider and spouse, ideally, as an understanding and supportive caregiver. Whether the experiences of spouses reflect this assumption will be discussed further in Chapter 8. Despite the stresses and strains of rural general practice, responses showed that few GPs wanted to leave.

### **'Rural practice is probably general practice at its best'**

The sentiments that 'rural general practice is probably general practice at its best' (AMGP2) expressed by an Australian trained, male rural GP were not

uncommon and indicated the great sense of satisfaction many GPs derived from their work in this context. The same GP also suggested that 'rural GPs have better morale, better incomes, and more fulfilling professional lives' (AMGP2) challenging negative views of rural general practice. He had been practising in a rural area for over five years and felt that the combination of lifestyle, diversity of practice and continuity of patient care contributed to his enjoyment of general practice. Several male colleagues of all ages echoed his sentiments and valued being able to practise 'integrated medicine' (AMGP8) in a location close to home, in an 'excellent clinical environment' where the GP is in touch 'with every level of patient care' (AMGP9) from 'the cradle to the grave' (AMGP7). One GP commented that just seeing the 'coughs and colds of city practice would be 'awful' and could lead to deskilling (AMGP7). He considered rural general practice a much better option to practising as an urban GP. The opportunity to do procedural work such as surgery, anaesthetics, emergency care and obstetrics was a factor that attracted many male GPs to rural general practice and influenced their decision to remain:

If I am blocked from doing that I will probably leave. I have spent a lot of effort, time and my family's time and money in gaining the skills and I don't actually want to be in a place where they won't let me practise them (AMGP6).

Some male GPs were bemused, and annoyed, at the financial incentives considered necessary to attract GPs to work outside the cities, as if to compensate for the sacrifice they were making. Most were proud to be rural GPs and rural general practice was often their first choice, made without the need for financial inducements:

Coming to the country was never considered by me to be anything unusual. It was a natural choice. I don't know what all the fuss is about, as if there is something strange to choose to work in the country, as if there is something abnormal about us. I chose the country for hedonistic principles. This is where happiness lay for me (AMGP9).

For others, rural practice was only an option if there *were* generous financial inducements and a 'very good lifestyle; (AMGP3) where 'there needs to be a strong push to make those places more attractive' (AMGP12). The way to attract

more GPs is seen to concur with the notion that GPs need to be compensated for working in a rural area that is perceived as deficient in supporting the work and lifestyle needs of GPs and their families. The solution to offer compensation by providing generous incentives implies the elite status of medical practitioners, reflected in their sense of entitlement in making such demands and having them met. This view does not explore the notion that the expectations of GPs might be unrealistic and warrant examination.

Kamien (1987: 41) found that most rural GPs in Australia were ‘mainly from middle or upper-middle class’ and would therefore ‘miss the trappings of middle class society’ by living and working in a rural area. Economic policies to restructure and develop rural communities have led to services being downgraded or withdrawn which has inevitably led to people leaving to find employment elsewhere (Tonts, 2000). Indeed, research suggests that rural GPs often cited the lack of services, few opportunities for paid employment for their spouses/partners, limited educational opportunities for their children and heavy workloads as constraining factors to working in rural areas (Strasser et al., 1997; Wainer, 2002).

### **The rural GP and the local community**

One GP commented that downgrading or withdrawing services from some locations as part of the economic restructuring and development of rural Australia did exacerbate the problem and ‘[took] the middle class out of country towns’ (AMGP10). He argued that professionals leaving rural locations led to the shrinking of local social networks for GPs and their spouses, making living and working in a rural location less attractive. However, larger centres offered more choice of services: nine of the 13 Australian trained male GPs interviewed lived and worked in Albany which had many attractions, providing opportunities to meet their social needs compared to smaller rural towns. Despite this, there were disadvantages to being a big fish in a small pond.

One GP reflected on the drawbacks of being in an elite position in the social order of the community. He claimed that some rural GPs isolate themselves from the rest of the local community by viewing themselves as different and entitled to certain advantages:

I think part of the problem is that a lot of doctors feel they can't mix with anyone else. They have to mix with the elite of society, lawyers, architects. I think they miss out by not mixing [with everyone] where you realise you are not the most important person (AMGP1).

Such a response suggests that some GPs' expectations of rural general practice focus more on what the community can do for them to make their experience enjoyable rather than what they can do for the community. This implies a sense of entitlement to have certain expectations met because of their privileged social position. Yet, according to one GP, this expectation could prove counter-productive in terms of GPs life experiences and understanding of broader social issues. He suggested that medical colleagues who live in a privileged environment were less able to appreciate and understand the negative experiences of those in the community detrimentally affected by such issues as rural restructuring and development:

For a lot of [GPs] they have no real experience of things like poverty. If you take a group of doctors: they grow up in a middle class background, go to a middle class school, attend a middle class university and then they work in a middle class area. How would they really understand how to get involved because they haven't had the training or had any personal experience (AMGP10)?

Another GP argued that structural factors reproduced the dominant position of rural GPs in the social order. He considered the division between the local GP and the community was reinforced institutionally. Policies continued to reflect the hegemonic status of GPs in the delivery of rural health services by offering them generous incentives and assistance to live and work in a rural area, incentives not offered to other workers. He thought this misguided:

Do [I] feel the need for all this support? Do pig breeders have a support groups?. ... RDAA (Rural Doctors' Association of Australia) sends stuff out to our wives saying "Myrtle is coping at Mukinbudin against all odds". Ridiculous. We are ordinary people who fit into the community. All this is separating the doctors from the community and making them an elite (AMGP9).

This raises the question of value attributed to work status in a rural community. The same GP bemoaned the fact that GPs now expect financial incentives to work in rural locations reinforcing their elite status:

I am not more special than anyone else. I am doing what I like doing. I didn't come here and expect the town council to turn on receptions and buy me a house and a car and a jarrah dining room table. Those incentives are over the top because the doctors have pushed it. Doctors want their 4WDs and luxurious houses. Because of the shortage of adequate doctors they have put more stress on local people to pay for them (AMGP9).

Nonetheless, research has shown that unless adequate incentives are offered that suitably reflect GPs' position in society, most would not consider living and working in a rural location. Because of their elite status and the shortage of GPs in rural areas, some GPs feel justified in expecting generous incentives from government:

The only way to attract someone is by money or a very good lifestyle or to force people to go there which is what the government is trying to do with the new training, or provide OTDs which is the cheapest way rather than offering some sort of subsidies. I don't think they are any closer to solving the problem (AMGP3).

Indeed, smaller centres, especially those supporting a solo GP, often oblige with offers of free or subsidised housing, car, equipped surgery and other incentives that are allocated from their annual budget. However, there were other disadvantages to having an elite status in the community. Some GPs felt they were expected 'to be perfect, and if not, we [the local community] want to know why' (AMGP10). Practising 'perfect medicine' (AMGP10) warranted:

...being on tap 24 hours a day and never having holidays. I think it is getting worse. When you go away people think you have abandoned them (AMGP5).

One GP suggested that the government also expects 'gold standard medicine on copper plated costs' (AMGP10). When mistakes are made in clinical practice, the rural community holds the rural GPs accountable which can make some GPs feel like they are living in a goldfish bowl:

You can't hide. In the city you can hide, you can hide your mistakes. Even specialists hide their mistakes and problems because their numbers are so huge. In the country specialists can't hide their problems. They have one problem and everybody knows about it. You just can't hide (AMGP7).

The idea that 'if you make a mistake you can't hide in small community' (AMGP8) suggests a level of exposure that makes any degree of anonymity difficult in a small location which creates its own set of pressures. The experience of being part of the community is intensified, particularly as some GPs commented that the community 'feel like they own the doctor' (AMGP8). This had implications regarding the boundaries between professional and personal life:

You don't have a choice if someone is having a baby or having a heart attack. A mother turns up with a kid at night-time. It is not an emergency to me but it is to them. For me to say 'go away' is an option but it is fairly difficult to say that to a distressed human being who has probably had a kid screaming all day. I guess you can but, looking at life compassionately, you don't (AMGP5).

Nevertheless, while there was a cost to pay in terms of workload, lack of anonymity, expectations of high standards of work practices from local residents and striking a balance between work and family life, most of the GPs I interviewed derived enormous pleasure from their work, their lifestyle and planned to stay in a rural area. When asked why more urban GPs were not attracted to work in rural locations one GP replied:

I have absolutely no idea. I am glad they don't want to come. I am very happy if they stay in the city. If you go to the country you have to know what you are on about. You have to know your limitations and you generally have to be pretty good at what you do (AMGP7).

## **Future of rural general practice**

Suggestions to improve the distribution of general practice services include allocating Medicare provider numbers according to geographic location so doctors practise where they are needed, rather than providing all doctors, once they have met their training criteria, with unrestricted provider numbers allowing them to practise in a location of their choice (Hamilton, 2001). However, such

suggestions have generally been vehemently opposed by the medical profession. Allocating provider numbers geographically is considered by many doctors as ‘civil conscription’ by the government and therefore unconstitutional (see Australian Medical Association, 2001b). Some responses from rural GPs support this view considering it ‘draconian’ (AMGP8) and ‘anti-constitutional’ (AMGP10). Others, however, responded more reflectively. One GP thought geographic allocation, while restricting the number of GPs practising in one area, could lead to those GPs with the provider number exercising a monopoly in a specific location:

It gives a huge amount of power to the government and to the GP who has a license for a certain area and no-one else is allowed to have one out there. I think that is very restrictive and the system stinks. ... If I hold the provider number in a particular area then the people there get what I serve up. They have no choice as I have the license. ... [The government] can say ‘you can’t be in Wyvern Village (pseudonym) because there are already four doctors there but you can be in Sunny Bay (pseudonym)’. I might not want to be in Sunny Bay so you get a disgruntled GP in Sunny Bay. It is the enforced licensing to geographical areas which limits everybody. I think the free market is a better option (AMGP6).

Another GP thought that a better solution to cope with the maldistribution of GPs was for the government to:

...allocate provider numbers to the practice, so the practice has a provider number rather than the doctor. That would lock practices into areas, whereas doctors are mobile. When you have a practice provider number you can go and work there (AMGP7).

This GP suggested that if a rural location needs five doctors, the practice is given a provider number that it allocates to the GP for the length of time he/she practices in that surgery. He argued that this offered a more effective solution. Currently, a GP with an unrestricted Medicare provider number has the right to set up practice anywhere, regardless of the numbers already practising in the same location, making maldistribution more likely.

However these responses still prioritised the hegemonic role of rural GPs in health care delivery, a role currently supported by local communities, where

enlisting the services of a GP was considered the most desirable option when considering rural health services. There was little critical analysis of the efficacy of this view in relation to the diversity of needs between communities and expected health outcomes. Services offered by other health professionals were seen as second best. Nurses were generally seen to fill the gap until a GP was available. Despite this, one GP did express the need to think outside this square:

We need people who have a vision and a desire for the health of the community to improve. We need to have people thinking in the bigger picture rather than doctors saying we want this and that (AMGP1).

Whilst some Australian trained male rural GPs are resisting structural requirements that challenge their autonomy and control over their work practices, others are becoming more reflective and considering other ways to approach rural general practice as a result of such changes. These included moving towards creating a balance between home and work. However, despite most doctors expecting to remain in rural general practice, there remains a shortage of GPs. Given the reluctance of Australian trained doctors to work in the country, vacancies are being filled by overseas trained doctors, a theme discussed in the next chapter.

## **CHAPTER 6**

### **Overseas trained doctors and their spouses in country general practice**

Australian trained medical graduates are reluctant to work in rural locations and overseas trained doctors (OTDs) are increasingly being relied upon fill the gap in those areas (Donovan, 2003; Roach, 2003). The Commonwealth government's recent Medicare Plus package projected an extra 725 full-time OTDs to be recruited by 2007 at a cost of \$432.5 million (Australian Government Department of Health and Ageing, 2004). Such a boost to current numbers reflects the dominant role the medical profession plays in rural health care delivery. Any diversity in health needs between rural communities is subsumed under a 'one-size-fits all' approach and the belief that a rural community needs a GP.

OTDs currently make up about 25 per cent of the medical workforce in Australia (Australian Medical Workforce Advisory Committee, 2005). Unpublished data from the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) indicate that, whilst most OTDs gained their medical qualifications in the United Kingdom and Ireland, many are recruited from South Africa. Increasing numbers are now being drawn from Asia, particularly India, Pakistan Sri Lanka, Malaysia and the Philippines (Birrell & Hawthorne, 2004: 91). Whilst studies have focused on ways to attract and retain rural GPs, limited research is available on the expectations and experiences of OTDs living and working in rural locations, and the factors influencing their decision to stay or leave. This chapter addresses the relationship between structural factors and social practice to address this issue. First, it provides a brief overview of the role structural issues play in enabling OTDs to practise medicine in Australia. Second, it focuses on social practice in light of political and economic factors and gender relations by examining the actions, expectations and experiences of 12 male and two female OTDs working in rural locations within the GSDGP. The experiences of 11 spouses of OTDs are also briefly discussed

though they are covered more extensively in Chapter 8. The chapter begins with a structural background, focusing particularly on political and economic factors, in which to locate the increasing use of OTDs in providing rural medical services.

### **Rural medical services and the employment of OTDs**

The mid-1980s saw the numbers of OTDs entering Australia escalating (Birrell, 1995) with doctors arriving initially from the Britain or Malaysia followed by non-Commonwealth countries including the Middle East and Asia (Birrell, 1997). In the 1990s, the government alleged an oversupply of medical practitioners in urban areas. AMWAC claimed that metropolitan centres were over-supplied with doctors at the expense of an undersupply in rural areas, evidenced by increasing numbers of doctors and declining doctor/patient ratios (Australian Medical Workforce Advisory Committee & Australian Institute of Health and Welfare, 1996).

Birrell and Hawthorne (2004) refuted these results and supported findings from research by Access Economics (2002), commissioned by the AMA, claiming there was an overall undersupply and maldistribution of medical practitioners. Birrell and Hawthorn argued that the Australian Medical Workforce Advisory Committee (AMWAC) was incorrect in assessing an oversupply and maldistribution of doctors rather than an overall shortage. They also indicated that government concern over budgetary costs led to legislation in 1996 being passed which restricted the rights of locally trained doctors graduating after 1996 to bill the Medicare system for patient services they had provided. These restrictions also applied to OTDs gaining Australian Medical Council (AMC) accreditation after 1996. Eligibility for these groups of doctors to bill Medicare rested on completing the Royal Australian College of General Practitioners' (RACGP) post-graduate, family medicine program. A quota of 400 new entrants onto the program was imposed, later raised to 450 in 2003, which effectively led to a slower increase in GP ranks. Prior to this legislation, any locally trained or accredited OTD could obtain a Medicare provider number as a GP. The Commonwealth government further reduced the number of doctors by preventing overseas students trained in Australia and doctors from New Zealand

from accessing the Medicare billing system until ten years after registration as a medical practitioner in Australia (Birrell & Hawthorne, 2004).

Birrell and Hawthorne (2004) argued that, since the 1990s, there had been a systemic problem of supply, rather than maldistribution, where the output of medical graduates had not met the demand in general practice, the hospital system or various medical specialities. This had resulted in shortages in rural general practice. Such a development led to increased pressure on the Commonwealth government to address the problem of undersupply, eventually resulting in the Medicare Plus program being introduced in 2004. According to Birrell and Hawthorne (2004), this change in direction indicated that the Commonwealth government's acceptance of AMWAC's 1996 findings was, in fact, misguided. The Commonwealth government now planned to increase the number of medical school places to meet long term supply needs as part of the program. This included opening five new medical schools in Australia.

One short-term solution to the problem of doctor supply advocated by AMWAC was to use temporary resident OTDs to fill the gap in services in those areas unable to attract Australian trained medical graduates (Australian Medical Workforce Advisory Committee, 1999). This policy, which looks set to continue indefinitely, was considered necessary to provide medical services in rural locations, at least until sufficient local graduates fill the places. In Western Australia, many hope that opening a graduate medical school at Notre Dame University in Perth in 2005 will help to redress this problem long-term, particularly given its focus on filling positions for general practice in areas of need.

However, what is not addressed in the discussion is the assumption that increasing the number of Australian trained medical graduates will provide a long-term solution to filling vacancies for GP positions in rural areas. Repeated findings have shown that Australian trained doctors are reluctant to move from the cities and governments cannot insist they work in areas of need without contravening the Australian constitution which prohibits any form of civil conscription (see Australian Medical Association, 2001b; Rural Doctors' Association of Australia, 2003a). There is no guarantee that new cohorts of

Australian trained doctors, once they meet the requirements of practice, will want to work in a rural area of unmet need, so the problem may well persist. Despite governments offering numerous incentives to encourage GPs work in rural areas, including retention payments, relocation grants, grants to work in isolated areas, training grants, locum support, individual and family support, GP positions in many rural towns remain vacant. In the interim, the number of OTDs being employed has increased to fill the gap (Birrell & Hawthorne, 2004).

Various initiatives have been implemented to attract more OTDs to work in Australia. OTDs are now included in the Department of Immigration and Multicultural and Indigenous Affairs' (DIMIA) Skilled Migration Program as a way to facilitate easier entry into the country. OTDs' inclusion in the program requires that their medical qualifications are accepted as eligible by the RACGP. Another proposal in the late 1990s used increased Commonwealth government funding to help the states and territories in Australia set up recruiting agencies to attract doctors to fill vacancies in rural areas. This resulted in the number of Category 422 visas being issued increasing from 664 in 1993-4 to 2496 in 2003-4. Category 422 visas are those issued to temporary resident OTDs for up to four years on the proviso that they work in an area of need designated by the state and territory in which they work. While most OTDs with these visas worked as GPs they were not required to have their medical qualifications assessed by the Australian Medical Council (AMC), a change that also included OTDs on Permanent Resident Visas (PRVs). This was not considered a problem as most OTDs with 422 visas were 'recruited from Britain or other Commonwealth countries' (Birrell & Hawthorne, 2004: 90). However, Birrell and Hawthorne (2004) argue that it is now becoming a problem as increasing numbers of overseas medical graduates are recruited from elsewhere where English is not their first language, some of whom have struggled to pass the AMC accreditation exams. Programs designed to assess and train OTDs to the standard required to pass the exams have been implemented in each state or territory rather than nationally. The exams themselves are also being modified.

However, some concerns about the Medicare Plus program have been aired. Birrell and Hawthorne (2004) agree with the Australian Doctors Trained Overseas Association (ADTOA), the peak national organisation for international

medical graduates in Australia, that any assessments of suitability are not biased against those from non-English speaking backgrounds (NESB). However, all agree that some form of assessment is necessary to practise medicine in Australia. Birrell and Hawthorne (2004) suggest some overseas based medical training may not be sufficient preparation to work in Australia and meet the characteristics of Australian patients' health profiles.

This raises the question of what constitutes adequate preparation for OTDs to work in rural Australia and to what extent are cross-cultural issues examined in the delivery of medical services? While the Australian Rural and Remote Workforce Agency Group (ARRWAG) (2004: 4) recommends that the development of assessment criteria should be consistent nationally and meet the 'standards of the learned colleges and university medical departments', other factors beyond medical training also warrant consideration. ARRWAG suggests that appropriate professional and personal orientation is necessary to familiarise OTDs with Australian rural culture. Cross-cultural understanding seems particularly relevant for those working in areas with high Aboriginal and Torres Strait Islander populations.

Doctors' cultural expectations, values and religious beliefs need considering particularly if they impact on health outcomes. Anecdotal evidence of rural GPs in solo general practice who are reluctant to prescribe contraception to teenagers based on their own religious beliefs, is a case in point. Patients in this instance may have limited options to seek other advice due to lack of access to services. Such a response raises issues, not just of the interface between a doctor's religious beliefs and medical treatment, but also of the impact of rural restructuring on limiting access to appropriate services that may affect patients' health outcomes. If high quality medical care is a goal for rural communities, then appropriate training for OTDs working in culturally, linguistically and geographically diverse areas is necessary.

Seeking ways to help OTDs and their families adapt to their new lives is also important and local communities are encouraged to support and help them settle in (Australian Rural and Remote Workforce Agencies Group, 2004). An initiative established in the early 1990s to facilitate that process was the Rural

Medical Family Network (RMFN), which offers social and emotional support to all rural medical families who are experiencing difficulties living and working in a rural location (Delane, 2002).

Selecting and recruiting OTDs is currently carried out by private companies as well as public sector agencies (Birrell & Hawthorne, 2004). One of the most successful initiatives to increase the rural GP workforce was introduced by the Commonwealth government in 1999. The Five Year Overseas Trained Doctor Program, discussed in Chapter 2, offers various incentives for OTDs to work in rural practices. The program has attracted approximately 250 OTDs eligible to work in Australia (Australian Rural and Remote Workforce Agencies Group, 2004). Yet, despite efforts to match the demand for medical services with workforce supply, Western Australia continues to fall short of medical practitioners based on population ratios. This is significant particularly as the state's population is predicted to grow to 2.3 million, a growth rate that is nearly double that of New South Wales and Victoria, suggesting that the reliance on OTDs to provide medical services is set to continue (Australian Medical Workforce Advisory Committee, 2005). The relatively low number of medical school places in Western Australia, compared with other states, is considered to be a major reason for the ongoing and growing reliance on OTDs, particularly in rural areas (Australian Medical Workforce Advisory Committee, 1999). OTDs perform a vital role in Western Australia where approximately 40 per cent of all rural GPs qualified outside Australia (Western Australian Centre for Remote and Rural Medicine, 2003). This leads us to consider how OTDs and their spouses have responded to structural constraints and adjusted to their new lives in rural Western Australia. The responses of those living in the GSDGP are now explored.

### **OTDs and their spouses: life and work in rural Western Australia**

Interviews with OTDs and their spouses/partners living and working in rural settings paint a diverse canvas of the diffusion of cultures. Differences in ethnic and professional backgrounds between doctors and their families intersect with differences between geographical locations and the communities in which

OTDs and their families live and work. This picture questions any notions of homogeneity when considering the concept of rural general practice. Threads of diversity run through OTDs' and their spouses' responses to settling in to their new lives even though commonalities exist. A noticeable theme emerging from participants' responses was a sense of cultural dislocation as participants adapted to the unfamiliarity of their adopted environment. Such feelings were offset by OTDs' enjoyment of their work and the welcome they and their family received from the community in which they lived. This type of response helped to foster in OTDs and their spouses a sense of belonging to the community. Both these factors often strengthened their resolve to remain in a rural area. An added bonus and contributing factor for GPs to remain were the opportunities to carry out procedural work in rural general practice. Several had worked in a rural environment before arriving in Australia and were experienced procedural doctors (see Table 11).

However, a significant factor that dampened OTDs' enjoyment of their work was the role structural forces played in clinical practice. Responses revealed tension and frustration as they, along with their Australian trained colleagues, struggled to come to terms with the level of government regulation and the threat of litigation in general practice. Bureaucratic requirements placed significant demands on their time, considered unnecessary by some OTDs. Increased calls for accountability and the very real threat of being sued led many OTDs to also practise 'defensive' medicine to protect themselves; they often ordered more investigations on their patients than they thought were necessary. According to one OTD, 'every patient is a potential legal battle' (OMGP8).

Responses of spouses of OTDs to living in rural Australia were mixed. They ranged from profound relief to finally live in a safe environment, where the threat of danger was perceived as virtually non-existent, to deep appreciation for the welcome and support they received from the local community in which they now lived, to grieving for the loss of a country, family and friends they loved. Some found the transition easier when their sense of isolation and cultural dislocation were tempered by meeting other ex-patriots living in Western Australia. Structural factors also impacted on their expectations and experiences living in a rural area. Most spouses conformed to conventional gender roles with

the woman as main caregiver, responsible for domestic tasks and the man as provider. Some female spouses prioritised this role and chose not to enter the paid workforce or they worked part-time in an occupation unrelated to that in which they were trained. Others, the minority, resisted such expectations to deny or minimise their professional or occupational aspirations. Instead, they attempted to pursue their chosen careers despite their frustration at the difficulties they encountered including the effects of geographic isolation on the availability of opportunities. In the process, they often felt frustrated at the difficulties they encountered when attempting to pursue their careers not least the effects of geographic isolation on opportunities. All female spouses of OTDs gave a high priority to their role as primary caregiver. Male spouses, on the other hand, actively pursued their career interests which often led to their GP partners working less and taking on the primary caregiving role once the men found full-time employment. Any reversal of roles where males took on the role of caregiver was considered temporary until they found full-time work.

Interviews were conducted with 14 OTDs, 12 males and two females from different countries in Asia, Europe and Africa who had lived and worked in rural Australia from three months to 15 years. Eleven spouses, nine females and two males, also agreed to be interviewed. The average age of OTDs was 48 years and spouses 43 years. Small rural and non-coastal group general practices in medium rural centres were staffed predominantly by OTDs. Six OTDs worked as solo GPs in small rural locations and seven worked in group practices in medium sized rural centres with only one working in the large rural centre, Albany. Male OTDs interviewed comprised 27 per cent of male GPs in the GSDGP and female OTDs made up 13 per cent of all female GPs working in the Division. Over 50 per cent of OTDs interviewed were part of the Five Year Overseas Trained Doctor Program. All but one participant were married or in committed, long-term relationships. However, one spouse had returned to her country of origin and another lived in Perth with her child and the family saw each other at weekends. One OTD worked four days a week in a rural location but lived with family elsewhere for the rest of the week. Interviews explored participants' responses to factors influencing their transition to life and work in rural locations within the GSDGP and factors contributing to their decision to stay or leave.

Several South African trained doctors had previously worked as rural GPs and were often experienced in procedural work having been required to work in public hospitals as part of their training. In this context, most had delivered hundreds of babies and performed numerous Caesarean sections. They were also surgically experienced with skills in orthopaedics and emergency trauma as well as anaesthetics. Some had also made the transition from being solo practitioners in other small Australian rural centres to living and working in medium-sized rural towns where they could practise as procedural GPs and do ‘what we were trained to do’ (OMGP 10). One had transferred interstate from a rural group practice to become a solo GP in a small rural centre. OTDs trained in South Africa constitute a significant diaspora in the GSDGP offering each other cultural, social and professional support. This factor contributed significantly to the settling in process by lessening the sense of isolation and loss of family, friends and culture following their migration to Australia. OTDs from other countries were often not so fortunate and the transition was more difficult.

### **In their own words**

#### ***‘Push-pull’ factors attracting overseas trained doctors to work in rural Western Australia***

A combination of ‘push/pull’ factors led many families to come to Australia. They ranged from a sense of adventure, to wanting to leave the political and economic climate in their countries of origin because they saw ‘the writing on the wall’ (OMGP10) in terms of diminished hopes for the future, to wanting to escape an environment where their lives were at risk. Moving to Australia offered hope for the future, a safer lifestyle, better prospects for their children’s education, opportunities to practise procedural medicine and the challenge ‘to do something different before we get too old’ (OMGP5). However, the transition was not always easy. Some OTDs and spouses were deeply affected by a feeling of dislocation from their country of origin, their culture and their extended family, others were subjected to racial taunts and some spouses were frustrated at the lack of employment opportunities to pursue careers in their chosen field. These experiences were softened when local towns welcomed

OTDs and their families and valued the contributions they made to the community.

The opportunity to work in ‘one of the best [medical] systems in the world’ (OMGP4) where facilities were good and the Medicare system guaranteed an income for the doctor was a significant ‘pull’ factor. This was enhanced by the sense of relief and gratitude to be living and working in a secure environment that was not underpinned by a culture of fear. Despite any difficulties, most participants agreed that the advantages of staying in rural Australia outweighed those of leaving and returning to their countries of origin.

### *Security*

One of the main reasons for leaving their countries of origin was the lack of security and the constant stress of living in fear, particularly for those who had lived and worked in Southern or Eastern Africa. Some arrived in Australia with few funds due to poor exchange rates or prohibitions on taking currency out of their country of origin. One spouse had hidden money in a suitcase because of constraints withdrawing it from the bank. In order to be able to leave the country as a family, she had smuggled enough money to a relative in another country to buy the family’s air tickets to Australia. Other families had left terrifying conditions, including home invasions, armed burglaries, hijackings or living in security compounds that felt like ‘we were always on the defensive; prisoners in our own gaols’ (OFSP7). Many saw security in Australia as a non-issue, relative to their experience back home, with one spouse commenting: ‘most Australians don’t appreciate what they have’ (OMSP2). According to one GP:

In South Africa people are under political stress, economic stress and the stress of change...There is very little stress here. I don’t think people in Australia realise how fortunate they are. If there is a murder in Australia, it is headline news. There are twenty to forty murders a day in South Africa and they often don’t make the paper (OMGP3).

One GP gave the increasing rate of HIV/AIDS in South Africa and increased risk of a needle stick injury in his clinical practice, along with the fact that the family home had been burgled, his sister hi-jacked and his friend’s surgery bombed, as some of the ‘push’ factors that led him to leave the country.

Another GP left his country ‘because he had to, not because he wanted to’ (OFSP2) when he realised there was no future for his children.

### *Incentives*

GPs with young families chose to come to Australia to live in a safe environment and to improve their children’s prospects:

The whole time we are reminding ourselves that we made the change for the children and if they are happy, fine. We might never adjust, but the children will, and that is OK. They are very happy. I worried so much about them and I didn’t have to. I should have worried more about myself! They are very, very happy and the schools have been good (OFGP 2).

Other pull factors included good working and living conditions. Several OTDs had contacted a recruiting agency to work in rural Australia. In most cases, the agency contributed to, or paid in full, the air fare of the GP but not the family, to come to Australia. Solo GPs were usually offered rent free accommodation by the rural shire in which they worked. In one town this comprised a large, well-appointed, new, five bed-roomed house and garden with the shire paying electricity and water bills, providing two equipped surgeries and offering the free use of a vehicle, which was also serviced by the shire,. This led to comments from one GP:

Where on earth would you get these types of luxuries? Clean surgery, friendly faces and people that say “don’t leave us”. I tell them they will have a difficult time getting rid of me (OMGP6).

In larger towns with group practices, accommodation and vehicles were generally not free but were sometimes subsidised. Standards of housing were not always high:

The first house we were put in was tiny. Fine. But there were three meat safes in the sitting room. It was only temporary. There was also a surf board on the wall and broken sofas (OFSP1).

Most OTDs who were interviewed worked in private practice. One GP was paid a salary by the recruiting agency with a view to taking over the practice once he had passed the RACGP exam. Another owned his practice but ‘fully

bulk billed for philosophical reasons' (OMGP5). In some locations GPs were required to contribute a percentage of their income to the recruiting agency for management costs in running the practice. According to one GP, this amounted to between 30 and 50 per cent of his income. However, corporations owning and/or managing general practices had its advantages for the GP, not least the opportunity more time to spend with his/her family.

### ***Cultural adjustment***

Most OTDs sought out other compatriots and, where possible, established or maintained pre-existing social and professional ties in a rural Australian context. This often involved travelling hundreds of kilometres during their time off to meet them. Despite the distance and working in different locations, this connection helped the settling in process. OTDs and their families were able to speak their language and experience a sense of belonging and support which lessened the feeling of cultural dislocation and loneliness from being separated from country, family and friends. It also highlighted cultural differences, illustrated in the responses of one GP when invited out locally by Australian families:

A few people would invite us over for dinner and even that would be different, the kind of food they serve. ...You only realise what your culture is once you leave it; the way you eat, the way you do things is different. We missed our food, our own kind of food, terribly. Our best times have been going [to visit] [ex-patriot] friends where we eat as we usually do and talk our language (OFGP2).

Notwithstanding the relief to feel safe and leave behind a culture of fear, and the proximity of other expatriates, some still yearned for their country, family and friends. One spouse who had lived in rural Australia for several years commented:

I ache deep down but still hang onto those things that [reflect] a better life. You miss the smells, the smells of Africa and South Africa (OFSP7).

Loneliness added to the difficulty adjusting to a new life. Some GPs and their families found the transition hard because of cultural, linguistic and religious differences and a lack of extended family and friends. One family was coping

with living in a small rural town with a population of under 2000 where the GP worked in a solo general practice. His wife was unable to work in her chosen profession due to lack of opportunities and no extended family to assist with childcare. They had previously lived in a large, bustling Asian city with a population of several million surrounded by extended family and social networks. Another male spouse with a professional career stayed at home for a year to look after the children while his wife worked. During this time, he found meeting people difficult and his spouse commented that he ‘felt like an alien for the first year’ (OFGP2). A female spouse, who had lived in a rural town for several years, recounted a similar experience when she first arrived:

I had no one, not one person to talk to. I was desperately unhappy. I would stop people on the road and say good morning and start talking to them. I started talking to myself in case I forgot how to talk (OFSP1).

Another spouse, resident for several years in rural Western Australia, recalls her difficulty coping with the shock of moving and adjusting to her new life. She acted as if she were adapting well because ‘I didn’t want to tell them how I had suffered and how I needed help’ (OFSP7). Whilst appreciating the welcome offered by the local community, she ‘just wanted to hide’. Others felt a tension between the need to be appreciative of efforts made by the community and be sociable, and the desire to be alone with their family:

It’s hard. Depends on the kind of person you are. I have always been a very private person and I work with people every day, so at the weekends I just want to be at home and spend [time] with my family. My colleagues have been exceptionally good and invited us to meet other people. But still, I prefer my weekends at home. I haven’t yet met an Australian person where I can say these are my good friends (OFGP2).

Coping with life in a new culture was often compounded by a sense of isolation. According to one spouse, this was helped by contacting the Rural Medical Family Network (RMFN) for support.

### ***Isolation***

One GP experienced the sense of isolation as relative. He and his wife had ‘never lived in a place as small as this’. In Africa, small, isolated locations

were 'ten times bigger than here'. Working helped him to settle in and meet people but the adjustment to a new culture and location was difficult for his wife:

My wife couldn't cope and returned [to her country of origin]. There was nothing for her to do. She had trained [in her chosen profession] and she was bored here with nothing to do. She had always worked and had never stayed at home before [so this was] a big difference (OMGP8).

His response highlights the particular challenges facing unemployed spouses who are coping with the cultural, social and geographical isolation. Spouses who had worked in their country of origin, but were unable to work in rural locations, lost their professional role, financial independence and sense of identity as separate from their GP partner. This loss was exacerbated by the long working hours of their GP partners, increasing their sense of isolation. One spouse from a different cultural and linguistic background was used to working full-time in the profession in which she had trained. Her extended family had looked after the children and she found it difficult to adjust to not working at all and having to do all the childcare. Her husband's long working hours compounded the problem to the extent that 'we are only together in bed' (OFSP5). She had lived in a small rural town for over 18 months and kept herself busy 'reading, doing patchwork and helping the [children] with their homework'.

Even when some doctors and their families made the decision to come to Australia for a sense of adventure or change, the isolation of some rural centres proved challenging:

Ten minutes after I came here I wanted to leave. Maybe it was ten seconds. But I had made a commitment to come and I thought it was unfair to leave. The previous GP from [overseas] stayed for six weeks and left ... If I had looked around and decided what I was going to do in Australia I would not have come to a rural area ... A lot of people who come over here don't realise how isolated it is (OMGP5).

Despite the challenges, this GP had stayed and had worked in the same rural centre for several years. The sense of isolation was cushioned for others by the welcome they received from the local community with one GP commenting that he 'didn't expect this friendliness, open-arms welcome from everybody that we have experienced so far. I haven't had a bad experience yet' (OMGP3). One

OTD enjoyed his work, despite its heavy demands, and spoke of his appreciation at the welcome extended to him and his wife by the local community. Community support fostered a sense of belonging in OTDs and their spouses and emerged as a theme in discussions with other GPs that staved off feeling 'isolated, like a man in prison' (OMGP6) and contributed significantly to the settling in process and overall enjoyment of rural general practice:

On Saturday there was a busy bee and all the staff came to do my garden. Tremendous. Different from back home. People are more supportive and friendly. It makes you feel you are part of [the community] ... Everyone calls you by your first name. It is a very informal structure. I find it perfect (OMGP6).

### ***Social adjustment***

GPs' involvement in social and community activities assisted the settling in process and enhanced the feeling of acceptance, belonging and wellbeing. There were those who welcomed the opportunity to be sociable, threw themselves into voluntary work in the community, helped at 'busy bees' and went drinking at the pub. One spouse who had recently arrived was 'delighted and relieved to be here, and eager to make friends' (OFSP2). A recently arrived GP working in a solo practice enjoyed feeling part of the community where he was invited out regularly:

There are fantastic people around here. I am part of the community. That is the only way you can survive in a community like this. You have to be one of them. If there is a party they call me. If they go to the pub they drag me out. I am part of it (OMGP4).

One family, however, kept clear boundaries between professional and private lives, working, but not socialising in the community. As a GP working in rural practice for several years, he found such boundaries become increasingly blurred as friends 'took liberties' (OMGP5) wanting 'after hours' consultations. He and his spouse eventually chose to keep their personal and professional lives separate and move the family elsewhere once his children started secondary school. Whilst continuing to work in the community, he travelled several hundred kilometres at weekends to go home to his family.

There were other families who wanted to be sociable, but invitations and support were not forthcoming even though local residents were friendly. This was rationalised in various ways from local people having ‘their own networks of friends’ where they ‘didn’t need us’ (OFSP7) to people being ‘scared’ to invite the doctor to their home ‘because I was on-call’ and ‘people have their own cliques’ (OMGP10). Another OTD commented that they had been in town several months and ‘hadn’t yet met our neighbours’ (OMGP9). Others’ experienced a lack of welcome from the medical fraternity:

That sense of welcome is lacking in Australian medical circles where they are all well established doctors and wives. They don’t think “there is a newcomer from a different part of the world”. I don’t think they think (OFSP1).

This sense of marginalisation was difficult for some spouses, particularly if they had limited opportunities to work outside the home. Of the nine female spouses interviewed, two worked part-time, one worked casually in her husband’s surgery and was also studying. Six were not employed in the labour market although one was keen to work when her children were older. Several established a social network through community activities including participation in the local school and craft groups, with one commenting:

There are wonderful organisations here including craft groups. I have made so many lovely friends. I think I have had more friends here than I made in the ten years we lived in [a rural area in country of origin]. The town offers quite an astonishing variety of activities for people living here (OFSP4).

While some spouses adjusted to not being in paid employment, OTDs were faced with the challenges of working in a different medical system.

### **Professional adjustment to rural general practice**

The dialectical relationship between structural factors and social practice is evident in the frustration expressed by some OTDs in the face of rural health services being restructured in the current political and economic climate leading to changes in the work practices of some rural GPs. The downgrading of smaller hospitals prevented some OTDs practising procedural medicine. Others were annoyed that more credence and value was not given to their knowledge,

experience and skills gained in their countries of origin by the medical bureaucracy in Australia. One GP was irritated that he was expected to sit the RACGP exam even though he had been working as a procedural GP in a rural area for over 30 years before arriving in Australia. Bureaucratic requirements in clinical practice, and staving off the threat of litigation for medical malpractice, are challenges faced by all doctors in Australia regardless of their training or place of work. However, the amount of red tape involved in clinical practice was considered excessive, time consuming, and more than most OTDs had encountered in their previous practices. Meeting bureaucratic requirements often led to frustration.

Procedural OTDs in group practices offered services such as obstetrics, surgery, anaesthetics and emergency medicine with some being very experienced in their field. Those in solo general practice, regardless of their expertise, were unable to offer this kind of service due to a reduction in resources when smaller rural hospitals were downsized. As a result, some GPs had made the transition from being solo practitioners to joining group practices in larger rural towns where they could practise their procedural skills. Several commented that the variety of medical practice was a significant reason to remain in a rural area:

One of the reasons I would never be able to work in a place like Perth is because I was trained to be a rural GP and I cannot see myself consulting day in and day out. That would be an insult to my IQ and integrity. It's not just about procedural work in the country. It is about seeing someone with pneumonia, doing an x-ray, deciding the patient has to go to hospital, prescribing the treatment, giving the I/V antibiotics, and following them through till either they are better or I can't handle them any more [and need to refer them on] (OMGP10).

The same GP raised the point that solo practices were 'not sustainable' despite initially being a satisfying environment in which to work:

[They are like] a dripping tap. You cannot be on-call all the time, even if you don't get called out (OMGP10).

Sustainability is only possible if GPs are available '24/7'. However, while he considered this unrealistic, it was not a reason to leave rural general practice:

I don't want to finish the bush scheme to get into the city. I have got no intention going to the city (OMGP10).

Other GPs were used to work practices demanding 24/7 on-call evoking the heroic image of rural general practitioners:

I'm used to that and we are not that busy. You rest when there are no patients and you work when there are patients (OMGP4).

Most, however, whilst enjoying their work, appreciated their time off even if it meant leaving town in order to have a break. However, the requirements necessary for OTDs to practise medicine in rural Western Australia did reduce their enjoyment of work.

### ***Bureaucracy***

Several OTDs were frustrated that bureaucratic requirements underpinning their eligibility to practise medicine did not recognise the diversity in their knowledge, skills, ability and expertise adopting instead a 'one size fits all' approach. Sitting the RACGP exam was mandatory despite some rural doctors having many years experience in their field in their countries of origin. Those who applied for eligibility to practice procedural medicine were irritated by the bureaucratic hold-ups. Most GPs were also frustrated at the amount of paperwork and the level of government regulation and control in clinical practice with a few considering leaving: 'if the bureaucracy becomes too much' (OMGP11):

It came as a helluva shock when I started here because I had never pushed around so much paper. And a lot of the paperwork is really irrelevant. It is not doing anything. We are gradually getting used to it. You can't get away from it with the Health Insurance Commission and all the bloody hoops you have to jump through there. A good example is the Practice Incentive Payments. A lot of hogwash. Why do we have to do care plans [for patients]? We are doing them anyway. I think all doctors do them wherever you have trained. For diabetics we check their sugars, cholesterol and send them to a dietician. That is a care plan in any case. So why call them enhanced primary care items and then get PIP for having a practice nurse, or doing so many asthma checks, or so many immunisations? It is a load of bullshit. We are not going to achieve anything by

doing that. We are doing it to please the bureaucrats (OMGP10).

Added to this, GPs were working in an environment of increasing litigation which affected the way they carried out their clinical work.

### ***Indemnity***

Interestingly the risk of litigation for medical malpractice was not seen as a major problem for some overseas trained GPs, nor was it enough to make them want to give up procedural work. On the contrary, some adopted the attitude that doing ‘what we were trained to do’ (OMGP9) and taking the risk was part of their job, particularly in an emergency situation, rather than succumbing to the fear of being sued:

It was incumbent on me to try and save a life rather than to phone an insurance company and say “will you give me cover?” while the patient deteriorates. So, I don’t care what the insurance or government does. I just handle situations as they arise (OMGP6).

Others commented that the fear of litigation led to practising ‘defensive’ medicine where doctors became increasingly cautious when treating patients and ordered more tests to cover themselves legally. In his country of origin, one GP would take a history, examine and diagnose the patient and use tests only to confirm the diagnosis. In Australia, ordering ‘three times more investigations and tests’ (OMGP3) was preferable to having the ‘finger pointed’ even though this GP thought money was wasted on unnecessary investigations. One solo GP reflected on the stress related to the threat of litigation:

Cost [and the fear] of litigation will influence everyone who is practising medicine. You don’t necessarily change how you practise medicine and continue to practise to the best of your ability but the fear or stress is that there is no guarantee to protect you from litigation and that is a stress. It is the fear of the threat of litigation. If something goes wrong, and even if it is not your fault, someone can sue you and that is your concern. You feel powerless (OMGP7).

One GP commented that a relative already working in Australia said ‘I was mad coming here because of the litigation’ (OMGP11). Government regulation and control over work practice, and the risk of litigation for professional malpractice,

were seen as time consuming distractions from the real work of being a rural GP, which was clinical practice.

### ***Professional relationships***

Support from other health professionals in clinical practice helped OTDs settle into their new work environment. The level of support experienced by OTDs varied. For some, it was outstanding. In one rural town there was a tangible sense of collaboration between hospital staff and local GPs as they negotiated to work for the greater good of the community. The local Health Service Manager/Director of Nursing (HSM/DON) played a pivotal role in retaining GPs trained overseas by supporting their professional needs and proactively establishing and building strong relationships. This included providing refurbished premises for a surgery close to the hospital, negotiating on-call rates and cover to ensure GPs have adequate time off, and organising one of the local service clubs to host a dinner to welcome new GPs and their spouses to the town. A spirit of cooperation and partnership between GPs and the HSM/DON is evident in their responses:

We all need each other. Without [the hospital] he can't do his job; without him, I can't provide health services to the community (HSM/DON).

The DON who runs hospital wants us here so tries to help. If you want something, she is quite open to discussion. She tries her best to find it for you. She even drives long distances to fetch equipment for you. She really goes out of her way. ... We work together really well. We do have our differences, ... but it is always in good faith that things are discussed. It works well and makes a huge difference (OMGP2).

Other OTDs were not so lucky. When support from health professionals was not forthcoming, their sense of anger and isolation increased. One GP commented that, after several years, his medical colleagues had not introduced him to some of the visiting specialists:

There was no attempt made by anyone to introduce me to any of them. And if you make attempts to try and meet them you are considered a bit pushy (OMGP7).

Another GP who enjoys rural general practice and ‘loves the work, the team work and the clinical job satisfaction’ to the point where he feels ‘one hundred per cent satisfied’, has reservations based on relationships in a broader context. Such reservations rest on his perceptions of institutional discrimination that has led to him to consider leaving rural general practice in Western Australia:

You are treated as secondary in Western Australia if you are from Africa. You are not given equal footing and opportunities as those from Europe. That is the truth. It is an unwritten law but it is there. You see, what you are given is quite different from what others are given. Those coming from Europe are given better deals, better treatment based on location, better support, more openness, better information and better financial rewards (OMGP8).

Some OTD also experienced discrimination in the attitudes and practices of some local health professionals, the effects of which spilled over into the community:

The other problem I had was because I came from Africa they thought I would be pretty backward. So, whenever I asked for drugs that were not available in Australia at the time, but have subsequently been made available, I was told that we didn’t have those primitive drugs in Australia. Two and a half years after I was here, I was introduced to the Medical Director by a senior member of staff as “the locum from Africa”. I wasn’t very impressed. ... This attitude has washed off into the community. It does make it difficult sometimes (OMGP11).

Such attitudes led one OTD to state ‘I could never stay here permanently’ (OMGP8).

For recruitment and retention to be successful, understanding and meeting the needs of OTDs in rural areas is necessary. However, adequately addressing those of their spouses is also important. According to Kamien, (1987: iv) ‘rural practice is a family concern and the success and retention of a doctor depends to a large extent on the adaptability of the spouse’. Most female spouses, despite their professional backgrounds, adapted and conformed to hegemonic expectations about the gendered relations by subordinating their own career aspirations to take on the role of primary caregiver in the home, supporting their GP partners and family. While some focused on the importance of this role, others felt frustrated at their loss of professional identity. Male spouses of female

OTDs also conformed to dominant expectations of their role as provider. Role reversal was seen as a temporary measure until they found paid employment outside the home and their GP partner could then work part-time. One female OTD who became the main provider found the transition ‘huge’ (OFGP2) and difficult. When her spouse found full-time paid employment, she reduced her working hours. Her choice highlights the need for future rural medical workforce planning to consider the choices female GPs make to work flexible hours to meet, not only the demands of their other roles, but also to enable their male partners to work full-time.

### **The future of rural general practice**

Some OTDs reproduced hegemonic ideas of health care by envisaging the future of rural health service through a medico-centric lens where the solution to attracting more GPs was to offer them more money:

If you throw money at people they go and chase it. If you pay people enough, they will do anything and will move (OMGP2).

Others suggested the need to increase the number of medical students from rural areas as they were the ones most likely to want to work in those areas. One OTD thought that reassessing the training undertaken by potential rural GPs was necessary, particularly in the light of indemnity:

We are farting against thunder. ... We are not training GPs who feel confident [to do procedural work] in a rural hospital; we are not training holistic doctors who are able to see the full spectrum of patient care, from the cradle to the grave and everything in between. Being able to know a little about a lot of things rather than a lot about a few things [is important] (OMGP10).

Notwithstanding the rise in popularity of technology in rural medical health care with the increasing use of telecommunications, or Telehealth, a more sustainable option considered by some was to move away from staffing small towns to offer medical services in large rural centres as ‘people aren’t scared to travel’ (OMGP10). Alternatively, several OTDs had worked extensively with nurse practitioners in rural settings in their countries of origin and considered

them ‘very experienced ...and extremely competent’ (OMGP1). They openly supported their increased utilisation in rural Australia:

The nursing staff here are well trained. Why don’t we use them better (OMGP1)?

Another sang their praises and believed they would:

...easily be able to take care of a town’s problems, lacerations, all kinds of things without any problems. That is an option (OFGP2).

An older OTD agreed, on the condition that nurse practitioners ‘knew their limits’ where ‘very clear guidelines’ were necessary for them ‘to know that they are not doctors’ (OMGP11). One GP suggested that using nurse practitioners ‘can work well with caution’ as long as their experience was backed up with ‘book knowledge’ (OMGP2). The provision of rural nursing services with adequate medical back-up was considered a solution to the difficulty of attracting doctors.

The dialectical relationship between structure and social practice is evident in OTDs’ responses to political and economic factors impacting on clinical practice. While increased levels of bureaucratic control caused frustration and tension, most OTDs were willing, where necessary, to change their practices to comply with the requirements. However, some intimated that, should levels of bureaucratic control increase, they would consider leaving. While the social practice of gender fell along conventional lines, some female spouses of OTDs were frustrated at the constraints imposed on their lives and expectations by living in a rural location. This led to some to take on the primary caregiving role full-time and, in some instances, to underutilise their professional skills if opportunities to work locally in their chosen field were unavailable.

While male GPs constitute the majority of the rural general practice workforce, the number of women rural GPs is steadily increasing. This development will impact on future rural medical workforce planning as female rural GPs challenge conventional work practices that do not serve their interests, and generally work less hours than their male colleagues (Australian Medical

Workforce Advisory Committee, 2005). The expectations and experiences of female GPs in light of structural changes are discussed in the next chapter.

## CHAPTER 7

### **‘Heroes and fairy wrens’: the social practice of female rural GPs**

Patients build up rapport with a female GP but she is not available on Tuesday and Friday so, if you are sick Friday night, you end up having to see the grumpy old male GP. All he wants to do is knock off, and he’s pissed off because the female GPs are never there when they need to be, when there is a rush on. There’s a bit of a grudge thing because the male GP has to run the jolly practice while females flit in and out like fairy wrens (laughs) (AMGP 6).

At one level, the quotation above paints a picture of a male rural GP who resents seeing the patients of his female colleague because it means extra work for him as she works part-time and is not available. At another, it suggests tension between two models of work practice. The conventional model of Western medicine and rural general practice has always been male centred where an ‘unacknowledged convergence between “medicine” and “male-practised medicine”’(Wainer, 2003: 69) has over-ridden the different needs of women doctors. This hegemonic approach to work practice involving long working hours is currently being challenged by female medical practitioners who want to strike a better balance between home life and the demands of their profession. They prefer to work within a model that allows more flexibility in working hours (Kilmartin et al., 2002; Lippert & Tolhurst, 2001; Pringle, 1998). In a rural setting this is particularly relevant given that childcare services may be limited or non-existent.

This chapter examines calls for changes to work practices by female GPs that intersect with hegemonic ideas of rural general practice. It considers the notion that increasing numbers of female GPs, and their demands for greater flexibility in working hours, are altering work patterns that have historically supported the interests of male GPs in a rural setting. The chapter illustrates that female rural GPs’ demands for changes at work are often predicated on dominant

ideas regarding the gendered division of labour at home. Women still retain the major responsibility for domestic and caring work in Western industrialised countries (Crompton & Le Feuvre, 2003; Hochschild, 1989; Sullivan, 2000). At one level, this is a significant factor contributing to female GPs' wish to work fewer hours. At another, the social practice of gender in the home, with women taking on the role of primary caregiver, intersects with the demands of the workplace causing tension between male and female GPs as women leave early to carry out the 'second shift' (see Hochschild, 1989). The chapter also explores whether women rural GPs working fewer hours is supported by male rural GPs. Hegemonic expectations require women to be the home-maker. Yet if the demands of that role intrude into the workplace, it is the female GP, rather than the organisational structure of medicine, that is held to account for not 'being there when they need to be' (AMGP 6), often resulting in longer hours worked by the male GP.

## **Background**

Socio-economic changes in the last 40 years in Western industrialised countries have led to women's increasing employment outside the home. Their entry into the market economy has altered their lives dramatically (Hochschild, 2003). The institutional structure of many professions has been organised to reflect a gendered division of labour predicated on the male in the workplace as provider and the woman at home caring for the family. Hochschild's (1989) research on the work structure of universities in the United States shows that work practice was designed to meet the needs of males who worked full-time and whose wives stayed home and raised the children. They did not cater for the needs of women who were the primary caregivers and who worked outside the home by introducing flexible working hours to fit in with their childcare responsibilities in the home. Work patterns in the medical profession in Australia have long reflected a male model of work practice (Pringle, 1998; Witz, 1992)

Theoretical perspectives on medical work practice were initially developed without reference to gender even though, according to Game and Pringle (1983: 14) 'gender is fundamental to the way work is organised; and work is central in the social construction of gender'. Instead, the workplace was

structured to present a biased view of organisational functioning that favoured the work practices of men and did not acknowledge, or meet, the needs of women who carried the main responsibility for childcare and domestic tasks in the home (Davies, 1996; Witz, 1992). This organisational structure has shaped the beliefs and values that inform work practices in medicine where the interests of women doctors are less well served than those of their male colleagues. In such a climate, female medical practitioners have made huge efforts to work within this structure notwithstanding their commitments at home (Crompton & Le Feuvre, 2003).

Women's complicity with hegemonic expectations of gender relations suggests an inequitable power balance between men and women where women generally carry the domestic and childcare load on top of their work commitments. Women may accept this construction as conventional wisdom and not consider it exploitative, despite it serving the interests of their male partners. Bourdieu (2002: 73) suggests that their 'doxic' or 'uncontested acceptance of the daily lifeworld' misrecognises the symbolic violence being perpetrated against them. Women's doxic acceptance of their central role of caregiver continues to exert a significant influence on their working lives. Findings from research by Crompton and Le Feuvre (2003) carried out in Britain and France show women doctors still retain the major responsibility for childcare and domestic tasks with many choosing general practice because they have more control of their hours. Hakim (2003a) carried out a national research project in Britain on women's difficulties generally when they attempt to combine work and family life. Her findings showed that, in the absence of financial need, only five per cent of mothers would choose to work full-time, three quarters would prefer part-time employment and 20 per cent would prefer not to work at all. Mothers who work full-time said their parenting role was central to their lives until their children had grown up and left home. Very few women sought to change conventional wisdom regarding the central place of motherhood in their lives in relation to their work outside the home.

Conventional models of medical work practice illustrate patterns that meet dominant ideas of masculinity and femininity with male as provider and female as primary caregiver. Male rural GPs are often able to work long hours

because their wives/partners subjugate their own career aspirations and become the main home-maker in order to support the GP and his practice. Spouses of female rural GPs are more likely to fulfil the role of provider and work outside the home (Wise et al., 1996) while their GP partners work part-time. However, Pringle (1998) cautions against adopting a position where women doctors are seen as victims to a male dominated, medical culture rather than as successful agents for change. She argues that, by virtue of women highlighting the need to question current practices, and their increasing numbers in the medical profession, they are making a difference to the culture of medical work practice which is slowly being restructured. This suggests a dialectical relationship between structure and social practice as any tension caused by female medical practitioners resisting conventional work practices is opening the door to change.

### **The feminisation of the medical workforce**

Hegemonic expectations of rural medical work practice to work long hours cause tension when they conflict with the interests of female GPs to meet the demands of their roles at home. The dialectical relationship between structural issues and social practice is revealed when dominant ideas about gender practices are accepted by female GPs in one context and resisted in another. Tension arises because conventional expectations of a rural GP's work practices are incompatible with expectations of being the primary caregiver in the home. Change occurs when female medical practitioners may choose to work fewer hours in the workplace so they can meet expectations to be responsible for childcare and domestic tasks, thereby reproducing the dominant belief of women as the primary caregiver. However, their male colleagues are frustrated that they have to 'pick up the slack' when female GPs go home. Rather than considering the role of structural influences on social practice, male GPs often implied that the problem is the female GP not 'pulling her weight' in the workplace.

GPs who respond to the inter-personal nature of the issue may fail to address the problem at a structural level that has long reflected hegemonic ideas of gender relations and supported the work practices of male medical practitioners. Women medical practitioners have adapted to a male model of work practice that has demanded 'a vocational commitment [and] a readiness to

be available 24 hours a day, seven days a week' (Pringle, 1998: 2). They have also tried to meet their domestic and childcare responsibilities. Expectations to conform to a male work ethic in medical practice and meet the demands of home-maker are unjust particularly when women doctors may be treated as inferior by their male colleagues and not be considered 'real doctors' (Pringle, 1998: 10) if they unable fulfil the 'vocational commitment' (p.2) to their work.

While women medical practitioners may not be victims to their circumstances, a broader interpretation of the problem does reveal how power relations within the social structure inform ideas about 'normal' practice in gender relations in specific contexts (see Connell, 1987: 120). Hegemonic ideas that essentialise or reduce gender relations to a clearly defined division of labour based on male as provider and female as primary caregiver are not recognising the complexity of the issue nor addressing the effects of these beliefs across contexts. If female GPs are disparaged and treated as inferior for not conforming to hegemonic ideas of rural medical work practices, even though they are complying with dominant gender expectations in the home, this constitutes a form of symbolic violence.

According to Wainer (2004: 52), female GPs who carry the main responsibility for their children 'cannot be on-call for their practice and their family at the same time without support'. Yet in rural settings, childcare services are often limited. Therefore, in order to meet expectations of their role in the home, female medical practitioners are calling for flexible working hours. Effectively, they are acting as agents for change in the workplace while conforming to hegemonic expectations of the division of labour in the home. While their calls for change in the workplace are not new, they are becoming louder as women enter the medical profession in greater numbers. This development is having a significant impact on medical work patterns in Western industrialised countries (Lapeyre, 2003; Wainer, 2001), a trend that is expected to continue (Riska & Wegar, 1993).

Beagan (2001) used 1996 data from the Association of Canadian Medical Colleges to show that over 52 per cent of Canadian medical students were women. Similarly, Incitti, Rourke, Rourke and Kennard (2003) drew on figures

from the 1998 Canadian Medical Association Data file to show that the number of female physicians increased by 166 per cent from 1980 to 1995 compared to a 26 per cent increase in the number of men. More women are entering the medical profession in the United Kingdom (Elston, 1993) and in France, over 50 per cent of medical students are women (Lapeyre, 2003). In Australia, women now constitute nearly 60 per cent of students in medical schools (Australian Medical Workforce Advisory Committee, 2005). Numbers of female GPs have also been increasing from 23 per cent in 1984-1985 to 34 per cent in 2000 (Australian Government Department of Health and Ageing, 2005; Hirsch & Fredericks, 2001). Over 50 per cent of GPs under 35 years are female (Australian Government Department of Health and Ageing, 2005) and women make up 60 per cent of GP trainees (Australian Institute of Health and Welfare, 1999b). It is anticipated that by 2030, 60 per cent of medical practitioners will be women (Australian Medical Workforce Advisory Committee, 1998). In 2003, nearly 30 per cent of the rural GP population in Australia were women (Australian Medical Workforce Advisory Committee, 2005).

Women's entry into the workforce in the last 30 years and the increasing feminisation of the medical profession provide an 'excellent opportunity to change the nature of work and attitudes to it' (Hamilton, 2003: 171). Not surprisingly, resistance to change prevails among some sectors of the medical profession where medical discourses on work practice often subordinate the work of female medical practitioners to that of males because women often work fewer hours and therefore are seen as less committed. This response effectively deflects from addressing structural elements that reproduce dominant ideas and practices in a rural medical context. The organisational structure of medical work practice and the gendered division of labour in the home constrain and often belittle women's attempts to meet their dual roles. Pringle (1998: 158) argues that many male doctors think of women as a 'part-time subsidiary force, helpful in dealing with psychological problems, but not real doctors'. The 'part-time subsidiary force' is a sentiment reflected in the quote by the male GP at the beginning of this chapter.

Nonetheless, Pringle (1998) contends that women doctors who call for changes to the fundamental 'vocational' beliefs and work practices of medicine

as a profession to better meet the demands of home and family demonstrate their sense of agency. However, women's wish for change is often predicated on the gendered division of labour at home. As women reproduce dominant patterns of gender relations in one setting and act as agents of change in another, the ramifications of their 'doxic acceptance' (Bourdieu, 2004: 168) of the role as caregiver in the home are felt in the workplace.

The dialectical relationship between structure and social practice is illustrated as women experience tension in the struggle to meet their dual roles. The potential for change emerges from this tension. Female medical practitioners who choose to work fewer hours to meet the demands of home are precipitating calls for changes to work practices favouring long working hours. Thus, the effects on rural general practice of female GPs conforming to dominant gender expectations in the home is destabilising the organisational structure of patterns in the medical workplace. Women doctors are drawing attention to the relationship between the public and private spheres showing that the two contexts are linked (Pringle, 1998). Their calls for changes to work practices are transforming the image of medicine from an all-consuming vocation, where the needs of patients are often prioritised over those of family, to medicine as an occupation requiring less time at work and leaving more time available for personal and family commitments (Carson & Stringer, 1998; Pringle, 1998).

The tension caused by this change in perspective is slowly transforming ideas about medical work practices. Research shows a shift in attitudes in rural general practice in Australia towards increasing demands for shorter working hours, a reluctance to undertake on-call work, and a growing demand for locum relief (Australian Medical Workforce Advisory Committee, 2005; Rural Doctors' Association of Australia, 2003b; Wainer, 2002). This shift in expectations is reinforced by growing numbers of male rural GPs also preferring a better balance in work and home life (Carson & Stringer, 1998; Strasser et al., 1997). Studies suggest that increasing numbers of men want to share responsibility for childcare implying that caring for the home and family is a parental responsibility rather than a predominantly female task (Carson & Stringer, 1998; Clearihan, 1999). However, men's aspirations are not always realised in practice. Overall evidence in Australia on the gendered division of labour suggests that, notwithstanding

hopes to share parenting more equitably, most men prioritise work over family (Bittman et al., 2004). Their contribution to domestic tasks and childcare is often in the form of 'helping' their wives in the home and with the children only if it does not interfere with their paid work and leisure time (Dempsey, 1992).

In one study carried out on the Australian medical workforce, in which 296 medical practitioners were interviewed of whom 51 per cent were female, findings showed that 95 per cent of women interviewees carried the main load for childcare. Not surprisingly, the careers of male medical practitioners were less likely than those of their female colleagues to be influenced by family considerations (Australian Medical Workforce Advisory Committee, 1998). Such findings again demonstrate that different work practices required by many female medical practitioners to meet the demands of their role in the home are affecting work patterns at a structural level and questioning the ethos of medicine as a vocation.

Female rural GPs' calls for flexible working hours to make meeting the demands of home easier have led to a change in attitude in some of their male colleagues working in rural areas as they, too, seek a balance between work and home. At one level, this development evokes Gramsci's idea of alliances being formed where one group, male rural GPs, supports the interests of another group, female rural GPs, in a way that strengthens the challenge to hegemonic ideas influencing work practices. At another, women medical practitioners are acting as agents for change, in Bourdieu's sense, by transforming work practices rather than internalising objective realities that do not serve their interests. This supports Pringle's (1998) idea that a major shift is taking place and that female practitioners are instrumental in transforming medical work practices.

### **Balancing work and home**

Although women currently comprise only 30 per cent of the rural GPs in Australia (Australian Medical Workforce Advisory Committee, 2005), their growing numbers in the medical profession generally are strengthening calls for changes to the organisational structure of rural general practice. Women want medical work practices that better reflect and values their identities and needs as working women and mothers (Australian Medical Workforce Advisory

Committee, 1998; Crompton & Le Feuvre, 2003; Wainer et al., 2001). Yet, despite more women making up the cohorts of incoming rural GPs, their needs are not well represented in policies and programs for rural general practice (Wainer, 2004). In Victoria, 65 per cent of female rural GPs reported being the main caregiver for their children and worked the least clinical and non-clinical hours. Sixty three per cent worked part-time with 83 per cent of female rural GPs claiming it was for family reasons (Wainer, 2001). According to Wainer (2000), rural medicine needs a better organisational structure to meet the needs of female rural GPs in order to attract and retain their services. A study carried out in rural Queensland reiterated this theme where findings showed female GPs need greater flexibility in work practice to better balance the needs of family (White & Fergusson, 2001). In Western Australia, a similar study investigating the needs of female rural GPs recommended government support for initiatives to explore different models of practice that are 'flexible and sympathetic to the difficulties faced by female GPs' (Roach, 2002: 5).

Female medical practitioners have a vested interest in instituting more flexible work practices that allow for shorter working hours in order to meet their other responsibilities (Crompton & Le Feuvre, 2003). Nonetheless, some female GPs continue to adapt their lives to fit in with a model of rural practice that espouses the values, experience, training and professional development of male practitioners who influence the organisational structure of the profession where overwork is seen as a sign of dedication (Bryant, 1997). They are often faced with a struggle of wanting to meet the needs of their family yet not wanting to rock the boat at work, a seemingly no-win situation as they try to juggle the conflicting demands.

Nonetheless, female doctors who take more responsibility for childcare and domestic tasks than their male spouses/partners are, by default, undermining vocational attitudes in the medical workplace by being unavailable to work long hours. However, conforming to expectations of their role in the home has led to their subordination in the workplace. Responses labelling female rural GPs as 'fairy wrens' who 'flit in and out' (AMGP 6) imply that not conforming to dominant work practices is unacceptable and leads to diminished status. Such a response is unjust in that it fails to recognise or meet the interests of women and

constitutes a form of symbolic violence that is embedded in discourses minimising female doctors' role if they resist hegemonic work practices thereby reproducing their subordinate status.

However, research has also shown that female medical practitioners are reluctant to confront the patriarchal structure of the medical profession even though it diminishes their work practices and their efforts to strike a balance between work and home. Findings from studies on female doctors in Britain indicate that conforming to social expectations, rather than confronting and questioning them, was the norm. Female doctors made choices during their training about traditional gender roles where they assumed they would take responsibility for any future home and family, which they frequently did (Crompton & Le Feuvre, 2003). In France, many female GPs also led fairly conventional domestic lives with the male as the main breadwinner (Lapeyre, 2003). Beagan (2001) suggests that changes to the prevailing values underpinning medical work practice require more than increasing numbers of women entering the medical workforce. She argues for the need to recognise gender bias in medical training. In her study of Canadian medical students she found that a universal concept of 'the doctor' is still biased towards meeting the needs and interests of male rather than female doctors and is therefore not neutral. Male social dominance and privilege underpins this representation and ignores the fact that knowledge in this context, as well as all knowledge, is socially constructed and therefore not 'objective'. Until male GPs see their own biases, and female GPs their inclination to accommodate the status quo at an organisational level, change will be slow.

### **Gender and rural general practice**

However, changes are afoot. Clearly, calls for more flexible work patterns by female doctors are destabilising the traditional values underpinning medical work practice by raising awareness of the needs of female GPs to carry out their traditional roles at home (Pringle, 1998). Yet the dialectical relationship between structure and social practice is reflected in the struggle between two different approaches to work practices and between women meeting dominant social expectations in two separate contexts. This struggle has caused tension, not least

because greater numbers of women are practising medicine than in the past thereby adding strength to their demands to work more flexible hours. However, from this tension, change is emerging. Research from Britain supports the findings of Australian studies that growing numbers of male GPs prefer a better balance in work and home life (see Strasser et al., 1997). Young et al. (2001) agree that change is in the air and goes beyond younger male graduates wanting to work fewer hours, challenging the underlying vocational beliefs and practices of medicine as a profession. This shift in attitudes to work practice appears more widespread in Britain with many GP principals of all ages opting to leave general practice because of long hours and lack of balance between work and family. They, too, want more flexible arrangements that allow part-time work, job sharing and managed career breaks, suggesting a shift in priorities from medicine as a vocation to medicine as an occupation.

To illustrate the dialectical relationship between structure and social practice, I draw on interviews with male and female GPs in the next part of the chapter. Tension is evident in responses that reveal diverse approaches to work practices. Dominant ideas support a 'vocational' approach to medical work practice in a rural setting that involves long working hours. This expectation has been embedded in an organisational structure of power that subordinates practices that resist that norm. Responses in interviews show that some male GPs denigrate female colleagues' commitment to medicine if they work fewer hours. Such responses underscore the belief that 'real' medicine is about dedication, working long hours caring for patients that demands time away from home and family. This belief also presumes the presence of a spouse who cares for home and family while the GP is busy working. It fails to take into account those female GPs who trying to juggle the demands of the workplace on top of meeting expectations of their role as caregiver in the home, and, in the process, are changing the structure of medical work practices.

However, as Connell (1977) suggests, the relationship between dominance and subordination is never total; 'circles of resistance' (p.207) contest and weaken the power and control of dominant forces and change emerges as part of the counter-hegemonic process (p.220). Women medical practitioners choosing to work fewer hours to better balance both roles indicates a shift in

attitude to work patterns. While this shift may not be universally accepted within the rural GP workforce, it is not viewed disparagingly by all male rural GPs. Notwithstanding various discourses embedded within work practices that relate to dominant ideas of masculinity and femininity, responses from some male rural GPs support the findings of other studies as they welcome a less rigid approach to work practice and embrace the opportunity to work less.

Seven (46.6 per cent) of the 15 female GPs working in the Division, agreed to be interviewed on their expectations and experiences of rural general practice and how they meet the demands of home and work. Participants include those trained in Australia and overseas. All were in committed personal relationships. Interviews lasted between 20 minutes and two and a half hours and some participants agreed to be interviewed more than once. They ranged in age from early 30s to late 50s. Responses from several of the 25 male GPs whom I interviewed contribute to the discussion on changes to work patterns in a rural general practice setting. I begin by locating female rural GPs' experiences of their work in a wider social context to illustrate factors attracting them to rural general practice, influencing their decision to remain, examining the extent to which political and economic factors are affecting their enjoyment of their work and exploring their ideas on the future of rural health care.

### ***Female GPs' experience of changes to rural general practice***

In light of political and economic changes, female rural GPs face constraints on their work practices similar to those of their male colleagues. Demands for increased accountability in the medical workplace have led to feelings of apprehension and the need to 'over-investigate and over treat [patients] because you can't risk not doing it' (AFGP1) for fear of being sued:

People here sue for everything. ... It makes you practise defensive medicine so you order more tests, do more things that are probably totally unnecessary and add to the whole cost of everything (OFGP2).

Increasing government intervention in clinical practice is a 'constant pressure' (AFGP2) and having to meet administrative requirements is 'time consuming' (OFGP2) and leads to general practice becoming 'less satisfying' (AFGP2).

Nevertheless, rural general practice is still seen as preferable to working in the city because of the continuity in the care of patients, the diversity of the work and actively contributing to the community:

This is my life. This is everything I ever wanted. This is part of a ten year plan. ... I just want to stay here. I deliver babies and in 20 years time I want to be delivering their children (AFGP4).

Other factors attracting women to rural general practice have included financial incentives and good accommodation, especially for those working as solo GPs where they can come home at the end of the day without worrying about:

... the bloody mud in the back yard and throughout the house and where am I going to put my child's clothes when there is no hanging rail in the wardrobe and the tiles in the bathroom where the kids fall over because the bloody tiling is so bad. Things like that (AFGP1).

Female rural GPs also acknowledged the difficulties recruiting and retaining rural GPs although their solutions to the problem fell within a medico-centric paradigm. 'Training more doctors for rural general practice' was seen as the best option as 'Western Australia doesn't produce enough doctors to service its needs' (AFGP4). Another GP agreed with this idea for different reasons that reflected the effect of changes to work practices:

There are going to have to be more medical school places because [rural GPs] are not going to want to work all the time (AFGP5).

The idea of training more doctors was more popular than allocating Medicare provider numbers according to geographic location which was considered 'restrictive' and 'would really stop doctors going to the country' (AFGP4). The increasing use of nurse practitioners as another solution to the rural health problem, while acceptable to some female GPs who thought sharing the load was 'great' (OFGP2), was seen as problematic by others:

The government can't think that a [nurse practitioner] is replacing a GP because they are not. We have had six years of medical school plus another six years of training, plus more. Not that a nurse couldn't do it. She could do it if she went back and did it. Maybe a salaried doctor would be better (AFGP4).

Another GP had not 'viewed [senior nurses] as opposition or competition', instead feeling 'a great sisterhood with female nurses', but argued that the doctor had ultimate responsibility for patient care:

Nurses don't want to bear responsibility for the consequences. I had a phone call in the middle of the night to say a patient was deteriorating. I asked [the nurse] if she wanted me to come [and see the patient]. She replied: "oh no, I just have to tell you about it". So, if anything goes wrong it is my fault, not my fault, but my responsibility. I couldn't believe it. There are some areas where [nurses] want to do everything a doctor does but they don't want to cop the flack if things go wrong (AFGP5).

These responses highlight the central role medical practitioners have played in rural health care which is again being contested as nurses become increasingly skilled and experienced and compete for services once offered only by the medical profession. However, such responses also raise the issue of ultimate responsibility and indemnity in health care for nurses as they seek to expand their role in rural health care. The downsizing of rural hospitals in smaller rural centres as a result of economic restructuring and development is another reform confronting GPs. As a result, GPs have limited opportunities to practise procedural medicine outside large and medium rural centres. This has contributed to rural general practice in smaller locations being considered even less attractive:

Funding cuts to small hospitals and not allowing minor surgery to be done will reduce the desire for doctors to work in rural general practice because there is less to do. ... Essentially they become a city GP doing day to day work in a very small town. They have none of the advantages of being a GP living in a regional centre (AFGP4).

Despite five out of seven female GPs working full-time, most considered their role as home-maker and/or being responsible for childcare as an important part of their identity as a woman.

### ***Gender relations in the rural medical workplace***

However, while 'gender is not self evident as an issue for the dominant culture' (Wainer, 2003: 75), it was implicit in the responses of male GPs.

Evidence from responses of female rural GPs showed that ‘gender is ‘fundamental to the way work is organised; and work is central in the social construction of gender’ (Game & Pringle, 1983: 14). A constraining factor for female GPs working in rural areas, that was less evident in the responses of their male colleagues, was concern about employment opportunities for their husbands/partners. One GP said, she would not have considered moving to a rural area had she had realised her husband’s difficulty in finding a job. Another female GP linked the importance of meeting spouses’ needs, which intersected with dominant expectations of gender relations, when considering issues related to recruitment and retention:

So if you want people to come to the country we have to make it OK for the spouses. The only reason my associates can work [long hours] is because their wives do everything. Their wives can’t work because to look after someone working that many hours you have to be able to make a home (AFGP4).

Spouses’ responses to this idea are discussed in Chapter 8.

The idea of medicine as a vocation has long been underpinned by gender relations where male work practices involving long hours are considered the norm and work practices of female medical practitioners wanting to work fewer hours, are subordinated to those of their male colleagues. Changes to dominant work patterns have been slow to filter through at the level of organisational structure in rural general practice. In the home, conventional gender roles with male as provider and female as primary caregiver are reproduced in many medical marriages/partnerships. This has created a dilemma for female rural GPs where expectations to meet their role as a GP intersect with expectations of their role as spouse/caregiver in the home. Their attempt to balance their roles often causes tension in the workplace in relationships with their male GP colleagues.

Rather than address inflexibility within the institutional structure to better meet the needs of working women with children, responses of rural male GPs in interviews tend to focus on the detrimental effects to themselves of female rural GPs working part-time. They showed little recognition appreciation of the added workload at home for their female colleagues. Instead, female GPs who worked part-time were more likely to be disparaged for not taking their professional role

seriously enough—‘(flitting) in and out like fairy wrens’. There was a sense of resentment amongst some rural male GPs that their female colleagues did not adequately share the workload like ‘real doctors’, because of the hours they worked, with the implication that most female GPs ‘have it easy’. In fact, there was a suggestion that, by working part-time, female rural GPs added to the workload of their male colleagues because they are ‘never there when you need them’ (AMGP6), resulting in male GPs working longer hours:

I very much support the feminisation of the workforce but if that means I have to work longer and harder, and it does look like it, then I will be putting pressure on those women to work more (AMGP5).

Male rural GPs often assume that their female colleagues, rather than the spouses of their female colleagues, would take time off to look after their children. The lack of consideration for female GPs’ domestic workload on their availability for work reveals the prevalence of hegemonic gender practices in the rural medical workplace that laud those available to work 24 hours a day. This evokes Pringle’s (1998: 10) notion that such work patterns are part of the ‘medical sublime’ that gives the profession a ‘priestly’ dimension. Medical practitioners expecting to do less are not ‘real doctors’ and are not being ‘serious about their career’. Such responses imply a form of symbolic violence where female rural GPs’ work practices are denigrated unless they conform to hegemonic expectations, despite also carrying the load of home-maker with responsibility for childcare.

### ***Female rural GPs’ responses to hegemonic practices***

Rather than challenge the inequity of institutional structures that expect women, not men, to work a ‘double shift’ when they go home, most female rural GPs adapt by meeting the demands of both roles as best they can, notwithstanding the negative responses of their rural male colleagues. One female GP working part-time reflected that rural general practice was still very ‘male’ in its attitudes to work practices and commented angrily on her experience of male colleagues’ perceptions of female GPs:

I was only a pretend doctor because I was only working limited hours a week and the government wasted all this money training you, so that you could just go out and have babies (AFGP5).

Some male GPs reflect these perceptions, commenting that increasing the ratio of female to male doctors was ‘completely wrong’ (OMGP10). It would constitute ‘a very big problem’ (OMGP13) that would have a ‘severe impact in rural areas’ (OMG10) because male GPs would be left to ‘carry the can’ (OMGP5). None mentioned the effect on female GPs of fulfilling the demands of their dual roles in the workplace and the home nor the inadequacy of the organisational work structure of medicine to effectively meet the needs of working women with children. One male rural GP reflected, somewhat bitterly:

If there are 20 GPs here and ten of them are women, the ten men will still have to do the workload if the women won’t (AMGP5).

Interestingly, another female GP concurred with her male colleagues regarding the negative effects on male GPs of women working part-time. She commented on the ‘huge impact’ of the increasing feminisation of medicine on the future rural medical workforce by drawing on notions of medicine that support male work practices:

It’s different for female GPs. We have children, we get married and we don’t always work full-time. So the amount of money it costs to train a [female] doctor is not always that worthwhile (OFGP2).

Such attitudes reproduce hegemonic beliefs about the gendered division of labour in the home. Once her partner found full-time employment, this GP dropped her hours to work part-time. British research found that the majority of women in dual income families saw their financial contribution as secondary to that of their male partner (Hakim, 2003b). More specifically, other research has shown that female doctors generally fell into the role of caregiver in the home where their male partner was the main provider (Crompton & Le Feuvre, 2003; Lapeyre, 2003). Another female GP who was interviewed reacted defensively to feminist claims that women doctors have been forced to comply with male patterns of

work practice. She argued that the issue was not related to gender but to commitment and enthusiasm:

I get upset about people doing surveys saying female GPs in the country have a hard time. There is a lot of feminist stuff we get set sent [with questions like] do the male doctors put pressure on you to work longer hours; do you feel this interferes with your life with your children? It is not whether you are male or female, it is more whether you have this passion and you want to work (AFGP4).

However, her later comments reiterated the centrality of gender in rural general practice and the cost to women doctors of finding a suitable solution:

Not many women do obstetrics because it ruins your home life. Not many females want to do it because there is this need to want to have children and you can't do both. It's hard to do both. A lot of my friends who are female GPs choose to work far less hours (AFGP4).

Historically, rural general practice has been predicated on the assumption of male doctors being married (Wainer, 2001), where childcare and domestic tasks are generally divided along conventional gender lines with their female spouse responsible for childcare and domestic tasks. Some male rural GPs commented in interviews on the importance of having a 'good, understanding wife' (OMGP2) to support them. According to one, this was enough to fulfil the needs of some of their spouses:

We just work, we are happy to work, our wives accept the role we play in the community and the fact that we work hard. Some protest and others don't. Some are happy because they see their spouse is fulfilled in their role and they are probably happy in it themselves (AMGP1).

These comments not only reflect hegemonic expectations about the caregiving role of female spouses, but also imply that this role is sufficient to meet their needs. In this case, roles are clearly delineated into male as provider and female as primary caregiver. Role definition for female GPs who are also spouses is more ambiguous. Multiple femininities operate as female GPs struggle to meet the demands of different roles which often causes tension.

### ***Multiple femininities of rural female GPs***

One full-time, female rural GP decided to embrace conventional expectations of rural general practice by working long hours and relished the experience. She and her partner had decided not to have children. She conceded that the demands of her work made it essential to have a partner who was fully supportive:

This is my life. This is everything I ever wanted ... (Medicine) is a vocation and a passion ... The main reason I can work (full-time) is because my husband looks after me. I wouldn't be able to do this if I didn't have him. He does everything, cooking, grocery shopping, pays all the bills. He works [outside the home] three half days a week. The rest of the time he runs my business, his business, our home and we have chosen not to have any children. If I didn't have him doing that, I couldn't do (what I do) (AFGP4).

Without a supportive partner prepared to take on the load of domestic responsibility, maintaining this level of commitment to their work is difficult for female GPs. Most interviews revealed that many struggled to balance work and family life particularly if they had dependent children. Central to their sense of identity was their role as a mother which was compromised when they worked full-time:

I have always been very involved with the children and I couldn't do everything any more [when working full-time] (OFGP2).

This response showed this GP's strong inclination to spend more time with family rather than less, conceding that 'it is very hard mixing career and children'. One part-time female GP stated that 'medicine is not my life, family is.' Indeed, she went on to say that the female GP's role as spouse/partner and mother is fundamental to her identity:

For women doctors, what they do is not part of their core identity. Most women doctors would say their core identity was as wife and mother and GP would be third (AFGP5).

According to this response, female GPs are reproducing hegemonic patterns of gender relations in a domestic context which is effectively challenging dominant

ideas of work practices in rural general practice. Female rural GPs seek changes to their work practices in order to accommodate their responsibilities as main caregiver in the home. It is the desire to spend more time with the family that is motivating them to instigate changes at work to better meet their needs rather than wanting to transform the organisational structure of medical work practice, even though this is occurring as an effect of their actions.

From a structural perspective, female GPs are faced with a dilemma. They are expected to be caregivers in the home yet, if they want to be considered 'real doctors' (Pringle, 1998: 10), they need to 'be available' to work long hours (AMGP6). This often creates tension as they struggle to fulfil their dual roles. One full-time female GP with dependent children who had reversed roles with her partner indicated the importance of her role as a wife and mother:

My job is an important part of me as a person but it is not more important than my family life (AFGP1).

Another full-time GP commented that reversing roles with her male partner in theory did not always link to practice in terms of a fair distribution of childcare and domestic tasks. She found that the 'problem' of 'sort[ing] out the children' (AFGP2) was still relegated to the woman in addition to her professional workload. Indeed, the poignant, and destructive, effects of supporting hegemonic beliefs are illustrated in their impact on this GP's sense of wellbeing:

Another challenge is balancing work and family in a way that you don't burn out and part of that is not wanting to be a hero. But, interestingly, I don't mind if my husband, children or I suffer, but if the patients suffer because I am burnt out I have to stop (AFGP2).

Clearly, expectations of gender roles in the home play a significant role in the work practices of most female rural GPs, often revealing the tension that exists in the relationship between the public and private spheres when one intersects with the other (see Pringle, 1998). Female GPs struggle 'with the profession, with husbands, and with forces deep within themselves', to resolve seemingly 'overwhelming contradictions in their lives' (Pringle, 1998: 159) when expectations persist about heroic notions of rural general practice and women as caregiver in the home. Providing solutions such as increasing

childcare facilities, does not effect change at a deeper, structural level, but helps female GPs adapt to the current, gendered division of labour at home and in the workplace thereby reproducing dominant work patterns where the role of female GPs in the workplace is subordinated to that of their male colleagues.

However, ‘circles of resistance’ (Connell, 1977: 207) to hegemonic views are occurring in the workplace as a result of social changes. One part-time, female GP in her 40s acknowledged that:

Women are less likely to be pushed into working a lot because we don’t buy this ‘we are just playing, pretending to be doctors,’ especially these days, when women have to pay their own uni education and are just entitled to get what they want (AFGP5).

Nonetheless, this did not stop the tension that emerged from trying to balance parenting and work roles, illustrated in the responses of one female GP:

My daughter felt that I wasn’t there for her when she was growing up because I was always working. I feel guilty about that but juggled work and family as best I could (AFGP2).

Despite the fact that the majority of female GPs whom I interviewed worked full-time, some rural male GPs considered that female doctors generally work part-time. Such attitudes reproduce the notion that women are more likely to work fewer hours because of family commitments, which effectively diminish their professional status. Few male rural GPs showed compassion for their female colleagues juggling their various roles. Some older male GPs rationalised female GPs working part-time with essentialist views of gender roles showing little understanding of the structural constraints experienced by many women in their role as a rural GP. Instead, male rural GPs’ legitimated the choice of their female colleagues to spend more time in the home by viewing women as ‘more compassionate and nurturing’ and wanting to ‘have babies’ as part of the ‘mother instinct’ (OMGP10) reinforcing their role as carers and nurturers. Few rural GPs critically examined essentialist notions of gender relations underpinning parenting roles or the distribution of domestic chores.

Some female rural GPs blamed themselves for their perceived inadequacies in parenting, rather than the institutional structures that perpetrate a

form of symbolic violence against women. Practices sanctioning a heroic dedication to work and the inequitable division of labour in the home where women carry the heavier load of parenting and domestic tasks are unjust. They create a double burden for most female GPs who work a 'second shift' making it more difficult to achieve a balance between work and home. According to one part-time female GP, balance is required for optimum wellbeing:

To be the best doctor you have to have a balanced life. You have to take your own advice and eat well and exercise so that less doctors will be coerced into being the Lone Ranger in the middle of nowhere doing it all ... It is just not possible to expect the doctor to be on-call 24/7 any more (AFGP5).

The demands of female GPs towards more flexible working hours are being echoed in the responses of some of their male colleagues who were mainly in their 30s and 40s. This group of rural male GPs saw the benefits of balancing the demands of work and home. However, they experienced resistance from other male GPs who conformed to work practices espousing the vocational nature of rural general practice. One older female GP who had internalised the conventional model of rural general practice as a vocation bemoaned the demise of the dominant work ethic in younger GPs who now consider 'lifestyle is more important than the job' (AFGP3).

### ***Multiple masculinities of rural male GPs***

One male GP commented on the 'huge expectations' (AMGP10) in the 1980s for male GPs to work long hours and take no part in childrearing at all. He wanted to work part-time when he was younger so his wife could also work and he could spend more time with family. He commented that this choice was considered an anomaly and viewed disparagingly by his colleagues. Hegemonic expectations about gender roles were evident in responses indicating that male rural GPs work full-time and do on-call work while female rural GPs are able to work part-time because of their family responsibilities. Twenty years later, male GPs wanting to work less was becoming more acceptable, at least in theory.

Calls by female rural GPs for more flexible working hours are beginning to have a ripple effect within the profession as they are echoed by some male colleagues. Some younger, male medical graduates are now making 'lifestyle'

rather than vocational choices that focus more on the balance between work and home. Two male GPs in their 30s also commented on the importance of having a 'happy family' (AMGP3) by working fewer hours. One worked 'semi-part-time ... to spend more time with [my family]' (AMGP3) with another commenting that 'my career is second to my family' (AMGP12). He further stated that his younger male colleagues were 'more into self preservation' by choosing to work less:

There has been a cultural shift. There is a lot more awareness about what is necessary to function well and a lot more political lobbying. ... It is not really acceptable to do the long hours and there is a reticence in doctors to want to do that now (AMGP12).

One full-time female GP noted the wisdom of this shift:

Younger male graduates also want less time at work... I honestly do think you are a better doctor if you have a balance [between work and home]. It is not normal to work as a doctor 24 hours a day seven days a week. It is not a life. It is not good for your children or your family life (OFGP2).

One couple in their 40s both decided to work part-time to 'free us up to do a lot more things together'. Neither espoused to an 'heroic' attitude of rural general practice:

I have met enough doctors who thrive on stress and deliberately choose to work in practices that would kill Annette very quickly (AMSP2).

Nevertheless, one GP who had opted to avoid stress by reducing the number of patients he saw every hour, commented that rural general practice was still:

... a culture of high achievement and working hard. Not a place for slackers but for 'A' grade personalities (AMGP2).

This sentiment was reflected in the comments of one spouse of a younger male GP discussing expectations in some rural general practices where GPs were 'workaholics' and private practice was about 'getting your head around time is money and having to make money for the practice' (AFSP2). One older male GP had conformed to the vocational work ethic for many years and became ill. He subsequently took off several months from work, and reflected on his

experiences and choices, gaining insight into the effects of 'a culture of high achievement and working hard' on his health and wellbeing. As a result, he actively worked towards achieving a balance between his work and home life:

I never expected my family to cope when I (was) at work (if) they (had) some serious problem. ... There were probably times when I should have been with them and I wasn't. I think I have learnt that I shouldn't ignore them. They are more important than my patients. My patients can always see someone else. ... Whereas my family have always ... had a lower priority than everyone else. I have tried to change that. The family were taking too low a priority. I think the generation x-ers will get it right...I have to respect their attitude towards work. It is much more balanced but I am not sure where all the doctors are going to come from ... (Our generation) works like crazy and the generation x-ers decline doing that. It makes so much more sense (AMGP6).

### **The future of rural general practice**

The increasing feminisation of the medical workforce has widened the lens through which to view and understand medical work practice. The dialectical relationship between structure and social practice is evident as female rural GPs challenge dominant work patterns espoused by many of their male colleagues often causing tension as women struggle to meet their dual roles. From this tension has emerged the idea that the organisation of medical work practices does not derive from a commitment to an 'heroic' vocational ideology; rather, it is shaped by changing social relations in which gender is a key factor. Thus, when increased numbers of women enter the medical workforce, they bring with them the social expectation and aspiration that as women, they will assume domestic responsibilities, especially care for family members. This has translated into increasing demands by women in medicine for greater flexibility in their working hours to accommodate the demands of home and work.

The responses of several female rural GPs who were interviewed for this project reflect the tension these demands generate as they conflict with the dominant mode of rural general practice that is strongly underpinned by a belief in medicine as a vocation where dedication to the job is reflected in long working hours. Yet it is difficult for female GPs to subscribe to this ethic and practice and also to be the main caregiver at home without becoming over-burdened. In

response, female GPs are opting for a different approach to work practice that permits them to incorporate their household and family responsibilities. This shift is contributing to a change in perspective from medicine as a vocation to medicine as an occupation, where fewer working hours allow more time to meet other needs.

The desire for changes to work practice for some rural female GPs is underpinned by gendered imperatives associated with women's assumption of caregiving and domestic responsibilities. It is the effect on work practice of these imperatives that is calling into question the organisational structure of rural general practice. Such change is clearly associated with the markedly increased numbers of women entering the medical workforce. This has led to a shift in priorities from medicine as a vocation to medicine as an occupation, an idea also reflected in the career aspirations of some young male graduates who are prioritising a 'balanced lifestyle' over medicine as a vocation by choosing to work fewer hours. Some older male GPs are also seeing the benefits of a balance between work and home.

Nevertheless, there remain pockets of resistance to this development within the rurally based medical profession who continue to work according to the demands of traditional medical work organisation and practice. Not surprisingly they experience overwork but often attribute it to female GPs rejecting full-time work arrangements. Few male GPs in this category critically examine their sense of entitlement that female GPs should share the load at work more equally and not leave 'when there is a rush on' (AMGP 6). When female GPs do leave work early to attend to the family, male GPs often feel frustrated that they are left 'holding the baby' at work. There appears to be little reflection on the inequity in the gendered division of labour where the woman carries the lion's share of the load in the home, a significant factor in her desire to work more flexible hours.

Transposing Beagan's (2001) idea of bias in the context of gender relations to a domestic setting throws light on the fact that, until male GPs see their own biases in gendered division of labour in the home, and female GPs their inclination to accommodate conventional gender practices, change will be

slow. Such responses maintain the prevalence of current practices that reinforce hegemonic approaches to the gendered division of labour at home and at work in a rural context. Given the increasing feminisation of the medical workforce, the efficacy of maintaining practices that subordinate the needs of women GPs warrants serious consideration in light of future strategies to recruit and retain doctors in rural general practice. Gendered imperatives associated with women's assumption of caregiving and domestic responsibilities is also a theme in the expectations and experiences of spouses of rural GPs, a topic which is investigated in the next chapter.

## CHAPTER 8

### On being a 'good' spouse to a rural GP

Bernard (1982) argues that there are two marriages<sup>28</sup> in every union - his and hers. The needs of both parties compete in a relational context though female spouses generally subordinate their needs to those of their male partners, reflecting the deep seated gender beliefs in Western culture where men's work and needs are more highly valued than women's (Bernard, 1982; Delphy & Leonard, 1992; Summers, 2003). Finch (1983) argues that when a woman marries, she marries not only the man but the man's job around which her life then revolves. This idea draws attention to Pringle's (1998) notion of the overlap between work and family that reflects the relationship between public and private spheres, an idea which is particularly relevant in the context of the committed relationships between rural GPs and their spouses. The structure and organisation of men's work often constrains the choices of women, particularly if they are financially dependent on their spouses and are expected to fit in with the demands of their husband's occupation (Finch, 1983). It is wives who generally make career sacrifices to support their husband's career over their own (Yalom, 2001).

In 1971, few women in Oakley's (1985) study questioned their role as caregiver in the home which was considered primarily the woman's domain although her husband may have 'helped' (p.159). Seventy per cent of women interviewed in her study were dissatisfied with housework, citing monotony, fragmentation and loneliness as frequent complaints, yet few disputed their primary responsibility for childcare and domestic tasks. Other more recent studies reveal the conservative orientation of many women in committed relationships who comply with hegemonic ideas in the allocation of gender roles with male as main breadwinner and female as responsible for childcare and domestic tasks (Crompton & Le Feuvre, 2003; Dempsey, 1997a; Hakim, 2003b).

---

<sup>28</sup> In this chapter, I use the notion of marriage interchangeably with that of a committed relationship between a man and a woman.

These findings are reflected in responses from interviews with the female spouses of rural GPs in this study. Instead of acting as agents for change to their subordinate status, most women made choices that reproduced dominant ideas of gender relations.

While the needs of medical practitioners have been the main focus of research on recruitment and retention, rural general practice also affects the GP's spouse, whose needs therefore also warrant consideration. Most rural GPs in Australia are male with economically dependent spouses (Australian Government Department of Health and Ageing, 2005; Nichols, 1997). Wise et al (1996), in their study on the extent to which being a rural doctor's spouse in Australia determined their occupation, found that the role of female spouses, who were the majority, was closely connected to supporting their partner, the practice and its patients which often led to their own professional or educational interests being subjugated. The study showed that female spouses' lives and activities revolved around their partners' medical practice far more than the lives of spouses of urban GPs. Male spouses of female rural GPs were more likely to be employed full-time earning an income outside the practice and to be working in their original professions.

This chapter identifies how hegemonic ideas about gender relations in rural medical marriages/partnerships are reproduced and contested. Gramsci's notion that hegemonic beliefs direct social consciousness can be applied in this context. This idea has been effectively developed in Connell's (1987; 1995; 2002) body of work on the social practice of gender. Connell (2002) argues that gender relations do not exist outside the social structure which endures because gender relations are reconstituted in social practice. A consensual reality is formed when subordinate groups, in this case women, agree with dominant ideas, values and beliefs about masculinity and femininity and the gendered division of labour and accept them as the norm or common sense.

When dominant beliefs and ideas are resisted at the level of practice the dialectical relationship between structural elements and social practice is revealed. Tension arising from opposing ideas provides space for 'new meanings [to] emerge' (Pringle, 1997: 79) where women who resist hegemonic

expectations of their gender role act as agents for change. In this light, they contribute to a plurality of femininities within the social practice of gender indicating that the dominance of one group over another is never total (Connell, 1977).

However, Pringle (1997) suggests that the community generally perceives notions of family as more authentic when they conform to essentialist views of being 'natural' or biological, as opposed to seeing the family as a social construction. Essentialist views of family have held sway in rural communities in Australia, a theme expanded later. Previous research has shown that female spouses of medical practitioners often conform to conventional gender roles in marriage and demonstrate less interest in pursuing paid work or study outside the home, unless it is related to their partner's general practice (Fowlkes, 1980: 29; Wise et al., 1996). Distance from the metropolitan centre, limited opportunities to work in their chosen profession, and a desire to be the main caregiver and support their partners' work are some factors shaping female spouses' complicity.

However, conformity to their prescribed role is occasionally resisted. Responses indicate frustration in some rural GPs' spouses at the constraints social expectations impose on their choices and sense of identity. Nonetheless, most spouses complied with such expectations and subjugated their own educational and occupational aspirations or adapted them around the needs of their family. Few discussed the possibility of their GP partners modifying their work practices and leisure pursuits to enable spouses to fulfil their own aspirations. Responses from male spouses revealed that they all worked or were seeking work. Those who were employed, including two had reversed roles and were the main caregiver, were working in their chosen field.

The link between structural factors and social practice in a medical marriage/partnership is significant in the questions it raises regarding recruitment and retention. As increasing numbers of women participate in the workforce, can we assume that female spouses of rural GPs will want to give up their careers in future to follow those of their partners? Given the reputed interest of fathers' involvement in parenting, are male GPs and male spouses of female GPs,

prepared to change their work practices to accommodate the career or educational aspirations of their spouses? To what extent would modifying the organisational structure of general practice address some of the problems of recruiting and retaining GPs?

The first part of the chapter locates rural medical marriages within a wider context of gender relations. It presents research that offers a backdrop to gender relations in marriage, medical marriages and marriages in a rural setting to illustrate the dialectical relationship between structure and social practice. This is followed by an analysis of ethnographic information that examines the expectations and experiences of spouses of rural GPs in response to their prescribed gender roles and their decision to remain in, or leave, rural general practice.

### **Hegemonic gender relations in marriage**

One reason dominant ideas of gender relations are reproduced is the persistence of influential cultural stereotypes about what constitutes a 'good' wife where 'the subservient female [is] dedicated to the satisfaction of her husband's needs' (Oakley, 1985: 157) over and above her own. Hakim's (1995; 2003a) more recent studies in Britain revealed that one third of women experienced home and childcare as their main focus in life and believed that women should not combine a career with a family. Two thirds of women agreed that a job was necessary to gain independence though many saw themselves, not as career women, but as contributing to the household income. They worked outside the home partly because of current instability in the job market where their paid employment was considered an 'unfortunate financial necessity' (Hakim, 2003a: 52) taking them away from their central role in the home. Across Europe, women continue to be 'heavily dependent' (Hakim, 2003b: 50) economically on their male partners. De Vaus' (1997: 6) analysis of findings from the 1989-90 National Social Science Survey and the 1995 Australian Family Values Survey show that 75 per cent of respondents supported the role of women as the main caregivers in the home and men as breadwinners and protectors of their families. It is this conservative belief system that shapes the role of many spouses of rural GPs. Yet, women continue to receive mixed

messages. They are offered conditional support in wanting independence and pursuing a career, but only if it does not interfere with their main role as caregiver.

The capacity of men to work full-time as the provider is facilitated by the dominant ideas of gender relations being reproduced. Dempsey's (1997b; 1999) research on women's perceptions of fairness about who did the housework revealed the belief that men's employment outside the home was seen as more important than women's. Most middle-class women considered allocating housework to women as fair and supported the idea that men were entitled to relief from housework if they earned more than their spouses. According to Dempsey (1999), even women with a higher occupational status than their spouses, and who contributed more financial resources than men to the family income, did not use these resources as a reason to change the division of labour in the marital relationship. Instead they remained responsible for the bulk of domestic tasks in a way that hid differences in occupational status in order not to threaten the traditional power base of the male spouse. A study in the United Kingdom on professional women contributing to household income reported similar findings and showed that many women feel guilty if they are not 'totally devoted to their home and caring responsibilities' (Benjamin, 1998: 777) and seldom use their financial independence as a power resource in their relationship. In these contexts, women place greater value on their spouse's role as breadwinner that is complemented by their role as caregiver, perpetuating their subordinate status and reproducing hegemonic gender relations. According to Tichenor (1999), rather than thinking this arrangement unfair, many women judged their success as wives and mothers in relation to how much work they did around the house, rather than the status of their job and how much they contributed to the family coffer.

Feminist challenges have revealed prevailing inequities in the division of labour in the home but appear to have done little to diminish pervasive attitudes and practices that relieve men from contributing equitably to childcare and domestic chores. In fact, women who want change, but are unable to effect it, are more likely to reframe what they had previously considered unacceptable as acceptable. One of the reasons for this response is to avoid contention within the

relationship for the greater goal of maintaining a harmonious marriage (Dempsey, 1997b; Hochschild, 2003). Increasing numbers of women entering the paid workforce take on the domestic load and childcare on top of their paid employment while their husbands are often relieved of such responsibilities (Bittman et al., 2004; Dempsey, 1997a; Hochschild, 1989). Brines (1994) suggests that the gendered division of domestic labour is less about who earns the bigger share of income and more about a way to symbolically conform to conventional practices regarding dominant views on what constitutes femininity and masculinity. Indeed, rather than supporting feminist challenges to the inequitable gendered division of labour, many women continue to make choices that reproduce current practices notwithstanding some who are their dissatisfied with the inequity of existing arrangements (Bernard, 1982; Dempsey, 1997a; Finch, 1983).

Such practices suggest women's doxic complicity with their subordination. They accept responsibility for childcare and domestic tasks, often in addition to working outside the home, rather than challenging the inequity of conventional wisdom in gender relations. Their 'uncontested acceptance' (Bourdieu & Wacquant, 2002: 73) of this so-called norm implies that women may misrecognise the symbolic violence being perpetrated and accept as axiomatic men's dominance even though their needs outside their caregiving role are considered less important or are not valued with women displaying less sense of entitlement to demand resources or meet their aspirations. Such beliefs and practices imply that, in accepting 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 2002: 167), many women may not acknowledge and therefore may not seek to change the situation by challenging their subordinate position. At another level, women's reluctance to contest conventional wisdom relates to what they may stand to lose if they do not conform.

Women's disinclination to challenge dominant ideas about gender relations is shaped by a lack of social acceptance of their role as breadwinners and men as the main caregivers (Hand & Lewis, 2002). Indeed there is limited support for role reversal at the level of social practice in Australia where '[a]nything which smacks of the 'feminisation' of men is likely to evoke the

image of wimp; clearly, the domesticated New Age man is steering dangerously close to femininity' (McMahon, 1998: 150). While Finch (1983) has argued that wives' domestic and childcare responsibilities constrain their opportunities to work, Hakim (2003b: 257-258) suggests that women 'are just as able as men and can perform equally competently in any occupation ... yet personally choose to be full-time home-makers or secondary earners who give priority to their families'. Their sense of indebtedness to their spouses as providers leads many to feel gratitude rather than resentment (Lennon and Rosenfield 1994 cited in Dempsey, 1999: 6). Such a view highlights the power of structural forces in influencing social practice. Women's choice to conform may well be linked to their wish to avoid conflict and secure a good family life and future for their children (Dempsey, 1997b), particularly if they are economically dependent on their partner.

Unpacking this idea to reveal a more complex, nuanced understanding is also warranted. It is important to acknowledge what women stand to lose if they do not conform to hegemonic expectations of their role. In the context of rural general practice, female spouses who are not employed, and/or who choose not to continue their education or training and who are dependent financially on their GP partners, run the risk of losing their professional or occupational skills that may jeopardise their employment prospects should their circumstances change. According to Baxter and Western (1998), women with fewer resources stand to lose more if the marital relationship is disrupted because of the constraints on their options. Dempsey (1999) suggests that when women gain more economic power their sense of gratitude lessens and their sense of entitlement increases and they are more likely to perceive injustice in the division of labour. However, women who have fulfilled their role as the primary caregiver in the marriage and have not worked outside the home, yet are dissatisfied and unhappy, have limited choices and are often unable to leave their relationships without significant socio-economic hardship (Connell, 1987). If they do leave, Tavris (1992) argues that their standard of living drops while that of their husbands' often rises considerably, so women are clearly more disadvantaged not only economically but also socially and psychologically (Steil, 1997).

For most women, 'the contrast between the standard of living that they enjoy while married and that which they can expect after divorce simply redoubles the pressures in favour of marriage' (Delphy, 1992: 139). What is evident is that many women err on the side of caution rather than revolution when it comes to challenging the prevailing gender culture within marriage. It seems that, rather than inequities in the division of labour creating an impetus for social change, women often make choices that reinforce such inequities. MacKinnon (1997: 89) suggests that the majority of women comply with their role by not rocking the boat and challenging their subordinate position, even if it means the extinction of a 'self' or identity as separate from their role as primary caregiver. Baxter and Western (1998) found that women with limited options were more likely to accept their husband's minimal involvement in household chores as fair than women with greater economic resources and more options outside marriage. Dempsey (1999), on the other hand, found that perceptions of fairness in the gendered division of housework were based less on economic factors and more on whether the woman felt her work in the home was valued by her partner. Dempsey went on to suggest that women who felt valued were more likely to be satisfied with the overall quality of their marriage. Maushart (2001) claims that many women accommodate the existing inequities within a marriage believing that a flawed relationship with their male partner is better than no relationship. Either way, hegemonic ideas of gender relations become internalised as part of the normal social order. Reproducing such ideas can be so successful that, rather than admit to unhappiness within marriage, many women may exaggerate their husbands' virtues and hide any private hostility with 'public protestations of loyalty and affection' as a way to 'protect' their marriages (Maushart, 2001: 158).

### **Reproducing hegemonic gender relations in the face of social changes**

The study by Bittman, Hoffman and Thompson (2004) on men's uptake of family friendly employment provisions in two Australian companies found that, notwithstanding men's increased interest in fathering and sharing childcare, and corporations becoming more family friendly though offering flexible

working hours, only 18 per cent fathers used flexible hours to balance work and family and 73 per cent did not use a single family friendly provision. No more than two per cent of men switched to part-time work to look after their children. Over two thirds of fathers with pre-school age children said their partners were the usual carer of the children. Responses from employees, supervisors and managers suggest that men who increase the time they spend in childcare could damage their careers, highlighting a contradiction between changes in attitudes in the workplace and actual practice. Added to this, the researchers found that masculine identity and being the economic provider are powerfully entwined with both parents acknowledging the centrality of the father's career and not the mother's. Indeed, notwithstanding aspirations to share parenting more equitably, most men prioritised work over family.

These findings reiterate that dominant ideas of gender relations inform decisions about family responsibilities and the allocation of roles. For many men, being the breadwinner remains the top priority (Bittman et al., 2004: 182). In Britain, a survey of working couples showed that 75 per cent of participants saw the husband as breadwinner and the wife as the secondary earner, if she was employed at all. Only ten per cent of couples reverse roles, usually only temporarily, although this number is slowly increasing (Hakim, 2003b). Men's involvement in the domestic workload and childcare remains slight in Australia compared to women's and is usually arranged on their terms with little criticism levelled at men whose contribution is non-existent (Bittman et al., 2004; Dempsey, 1990, 1997b; McMahon, 1998).

Komter (1989: 208) analysed power in marital relationships in the Netherlands and examined the notion of an 'implicit hierarchy of worth' where cultural norms placed higher value on male as provider according them greater power within the marriage. Komter viewed power as relational but acknowledged the link between structural elements, such as the significance of economic factors and gender relations, on social practice in marriages. She defined power in marital relationships as 'the ability to affect consciously or unconsciously the emotions, attitudes, cognitions or behaviour of someone else' (p.192). She suggests that women's power to challenge the prevailing inequity in gender relations is suppressed when they choose to avoid conflict in their marriage.

Komter argues that women who find ways to adapt to dominant ideas of gender relations in marriage, however inequitable, legitimate the social order. Her findings showed that, in many cases, consensus between couples on the division of labour reproduced essentialist views of gender roles where childcare and domestic tasks were seen as 'natural' for women, who were seen to 'enjoy parenting more than men' (Komter, 1989: 209). Such views were also evident in Australian research on gender relations in a rural setting.

### **Marriages in a rural setting**

Dempsey's (1990; 1992; 1997a) studies on gender inequalities in marriage were part of his extensive research on rural Australia. His studies show that marriages are often so 'palpably one-sided that we are justified in describing them as exploitative' (Dempsey, 1992: 64). He also found that men *and* women living in rural locations often regard 'wifeness and motherhood as the natural and ultimate roles for women' and men are the 'family providers' (Dempsey, 1992: 171). Such essentialist views of gender are reflected in expectations that a wife supports her husband, not just in his occupation but also in his leisure pursuits and altruistic activities such as public service in the community where husbands 'cover themselves in glory' (p.64). If their husbands are in leadership positions, wives are expected to support them by freeing them up 'for play' (p.64) often at the expense of wives' own leisure activities, suggesting that a husband's claim to leisure is superior to a wife's. The belief prevails that, as breadwinner, the male is entitled to leisure time especially leisure time away from home (Dempsey, 1992). As a result, being responsible for supporting her husband and looking after the home and family constrains rural women's participation in the workforce and her own leisure pursuits. Rather than the load being equally shared between the couple, rural men conform to conventional stereotypes and 'help' their wives with childcare and domestic tasks as long as these activities do not encroach significantly on their own paid work and leisure pursuits.

Dempsey's research demonstrates perceptions in rural communities that men's role as provider is seen as superior to women's role by both sexes. In rural Australian culture, pervasive gender inequalities are evident in the notion that

men's work and needs are more highly valued than women's (Dempsey, 1990). As provider, men are entitled to more control in public and domestic affairs, a larger share of resources and more right than their spouses to pursue leisure interests. Their hegemonic status is reflected in their economic superiority that is endorsed by the community where women's inferiority is implicit (Dempsey, 1992). This is not to suggest that women begrudge this role. Many, according to Dempsey (1997b: 18), enjoyed carrying out some household tasks and looking after their husband and children, and valued the power they exercised in the home.

Alston (2005) also argues that gender is a defining feature of Australian rural community life. However, while hegemonic expectations of gender relations are open to contestation, their prevalence within the institutional structures and practices in rural communities is normalised rather than resisted, effectively marginalising women in roles outside that of caregiver. British and Australian research into women in rural communities offers numerous examples of women's careers taking second place to their mothering role (Alston, 2005; Halliday & Little, 2001; Little, 1997). Women who are highly educated and trained who move to a rural location often downsize their career aspirations by taking on unskilled work in order to fulfil their role as caregiver (Alston, 2005; Little, 1997). While limited opportunities for childcare in rural areas are a factor constraining women's employment choices, so also are expectations of women's role and identity. In a rural setting, expectations of women as primary caregivers impact on the gendered division of labour in the home and on women's ambitions in the workplace (Little, 1997). While it is important to recognise that multiple femininities exist in a rural context, Little (1997) nonetheless argues that certain characteristics are shared. Women's roles as wives/partners and mothers are considered a defining aspect of their identity which is given priority over their employment.

Women's doxic acceptance of their role as caregiver is reflected in the assumption that 'their employment necessarily took second place to their childcaring role' (Halliday & Little, 2001: 430). Empirical research in Britain on the provision and use of childcare in Devon revealed that 95 per cent of the primary carers in the study were women, with 91 per cent of fathers working

full-time. To accommodate their caregiver role, many women worked shifts or night work often 'at the expense of their leisure or sleep yet they did not define it as a problem when asked about childcare arrangements nor did it emerge explicitly as an issue in their conversations' (Halliday & Little, 2001: 430). Women's reluctance to seriously question inequities in gender relations helps to sustain and reproduce hegemonic ideas and practices. This choice deflects attention from examining the fundamental inequity in an organisational structure of gender relations that privileges the needs of men over those of women. Women's lack of resistance to conservative attitudes giving them responsibility for childcare was reinforced in their responses in the Devon study suggesting that they considered men's employment more 'fixed and non-negotiable' (Halliday & Little, 2001: 434). Few women suggested their husband/partner change his working day or week to help with childcare. According to Alston (2005: 154), '[h]egemonic masculinity ensures that men have a stronger negotiating position around domestic labour and therefore may make themselves unavailable for household work'.

Women's responses not only indicate complicity with dominant views on gender relations, but also misrecognise the symbolic 'violence that is wielded' (Bourdieu & Wacquant, 2002: 168) where power is inequitably distributed to benefit men more than women. Seeking a clearer understanding of women's complicity warrants a deeper investigation. Women in their subordinate role are more likely to be valued in the current social order if they conform to dominant practices. Indeed, those who are married or in a committed relationship may accept their subordination in order to reap advantages such as social acceptance. In the case of doctors' spouses, such benefits may also include social status, material wealth and financial security, which they could stand to lose if they demand change to the structural inequities present in the prevailing social order. According to Finch (1983: 28), the wives of men who undertake 'noble endeavours' that curtail time spent at home, often do not express any relational conflict this may generate. Instead, they give their husband even '*more* space to get on with great work' (*italics in original*). Such evidence is reflected in findings from interviews with several female spouses of rural GPs who placed high value on the GP's work and justified the importance of their own role to support his

work and leisure pursuits. Male spouses of female GPs who were interviewed for this project also conformed to dominant expectations by earning an income or looking for employment, even if they were the main caregiver.

### **The social practice of being a rural GP's spouse**

I interviewed 21 spouses, 16 female and five male, about their expectations and experiences being married to, or in a committed relationship with, a rural GP. All but one couple had children. Eleven of the 21 spouses (52 per cent) were partners of OTDs. Ten of the 16 female spouses (63 per cent) conformed to expectations of their role as full-time support and caregiver to their partner and family. Six (38 per cent) were employed outside the home where all except one worked part-time with two employed in their partner's practice (see Table 13). Six women had given up their careers in order to move to the country and three spouses found there were no openings in their field. None in this group was in the paid workforce though four planned to find employment in future and two were undecided. One spouse continued working in her profession even though it meant living away from home for several weeks at a time. Two others had changed careers with one creating a position for herself in a different field where she worked part-time; the other was unemployed though planning to find work. Two spouses were studying, one of whom also worked part-time.

Five male spouses were interviewed: one enjoyed being the home-maker and worked part-time, one reversed roles with his wife for several months until he found work, one was planning to look for part-time work so he and his wife could spend more time together, one worked from home to look after the children and one was actively looking for employment.

Conformity to hegemonic gender relations was a strong theme in the responses of female spouses, all of whom carried the main responsibility for childcare and domestic tasks. While all male spouses were working or looking for employment outside the home, two resisted hegemonic expectations and also took on the major load of looking after the home and/or children.

The dominant role of rural GPs in the delivery of health services and the esteem in which they are held in rural communities are reflected in responses from spouses. Many considered the work of the rural GP as the pivot around

which the life of the spouse and family revolves. While male spouses worked or planned to work outside the home, female spouses' wish to develop an identity as separate from that of doctors' wife by finding employment or furthering their educational aspirations was often contingent on meeting the needs of their partner and family first.

### ***Moving to a rural area***

Even though some were ambivalent about the decision eight female spouses (50 per cent) moved to a rural area mainly to accommodate their partner's choice. Notwithstanding their partner's wishes and the better opportunities offered their children, not all wanted to leave the location in which they had lived before coming to Australia:

I was very happy where we were, working [in my career] which was fantastic. ... I dug my heels in initially because I was pregnant at the time and we had bought a lovely new house and were getting settled. So, for me, it was very difficult to make the decision. I was secretly hoping we would stay. But when I saw how unhappy Graham was, I thought, well, what have we got to lose, we may as well go. ... Ultimately if Graham is not happy then it affects the whole family (OFSP3).

Another spouse was also reluctant to move to a rural area because of lack of career opportunities:

...moving away was like saying I can't go back to work in that field. ... I loved my work (AFSP1).

Two made the choice to move because their partners were 'unhappy' (OFSP3, OFSP4) in their job, thereby considering their partners' happiness over their own. Another woman eventually encouraged her husband, who was reluctant to leave his work, to move to rural Australia because of dangerous living conditions in their country of origin. Farm invasions were common, food was scarce, local currency was devalued leading to greater insecurity and fear as law and order broke down. Despite such conditions this spouse commented that 'you kept believing that things would improve, so you stayed' (OFSP2). One woman, whose husband had always wanted to practise medicine in a rural area, agreed to move:

I have just always known that and accepted it. I never made the conscious decision that I wanted to live in the country (AFSP2).

Spouses' willingness to accommodate the needs of their partner and family reflected their supportive role. One spouse measured her own happiness in her success in the role of caregiver:

Family is most important. If my husband and children are happy, I'm happy (OFSP6).

### ***Conforming to hegemonic gender relations***

Female spouses conformed to dominant expectations of gender roles by prioritising their husbands' careers over their own educational or occupational aspirations. They organised their lives around the work practices and leisure time of their GP partner. One woman with older children reflected on these choices:

In those days, I was quite content to fit in and be the good wife and mother where everything is for the kids or the family or the husband. ... I just accepted it as my lot. When you married a doctor, you knew this is what happened (AFSP7).

This response was not uncommon in current young mothers:

Edward is pretty strong about having the mum home, or, you know, a parent at home to look after the children when they are very little. I can definitely identify with that. It hasn't been such an issue for me to get back to work (AFSP1).

Women's role as carer was further legitimated when GPs validated their spouses' support:

Max is fantastic and said he couldn't do his job if he didn't have someone there behind him to smooth the way and make sure there is food in the cupboard (AFSP2).

Female spouses prioritised not only their supportive role, but also the dominance of the medical profession where many considered their husband/partner's work as a rural GP more important than their own career or educational aspirations. Some spouses legitimated their primary caregiving role as necessary for doctors to successfully carry out their work in rural general practice:

Everything revolves around Aiden. [GPs'] jobs are so important and their physical, psychological and emotional wellbeing are so important. I cannot compare the job they do to anyone else's in the world in terms of the demands placed on them. The public lacks insight that they sit up all night with a sick child and then go to work the next day. They need to debrief at the end of the day and [the spouse] has to have the time and energy to support that. ... Wives are so essential especially in remote areas. If the wife isn't there the whole thing crumbles (OFSP8).

The work of rural GPs was seen as vocational, noble and self-sacrificing, occupying centre-stage to the wife's backstage role.

The importance of his work is so deeply ingrained. The whole house revolves around him getting to the hospital on time. His whole day is self-focused and the wife runs round and picks up all the pieces. Without the wife doing all that, [the GP] falls apart (AFSP7).

Nonetheless, some women found it 'frustrating' (AFSP2) when they were unable to meet their social or educational commitments because of the demands of their GP partner's work. Rather than prioritise their needs and negotiate options with their partner to facilitate meeting those commitments, one spouse subordinated them and rationalised that the needs of the patient were more important than hers:

It is just the way it is. It is the nature of the work. Most good doctors care about what they are doing and they want to do a good job...I really admire a doctor who takes pride in staying back 15 minutes to talk to a family who has had a major trauma. If you don't accept it I don't think you survive in the relationship (AFSP2).

Such comments were offset by:

... huge expectations for male doctors to work long hours, full-time and take no part in child rearing at all. Wives are expected to emotionally support their husbands (AMGP10).

One spouse suggested that rural GPs' wives 'were like women in the 1950s who devoted their lives to caring for husband and family rather than developing their own identity' (AFSP3). She revealed the tension in trying to meet dominant

expectations and her own needs concurrently, commenting that, even if they worked outside the home, wives felt they were in a no-win situation because:

Who will look after the children? If [the GP] is on-call who is going to maintain the home? It is a huge dilemma. That is why we aren't working (AFSP3).

Yet, by staying at home, some women felt 'unfulfilled' (AFSP3) and 'frustrated' (OFSP1). Nonetheless, decisions centred on giving priority to their husband's work over their own career reflecting fundamental assumptions of their subordinate role in gender relations. While this choice reaped certain advantages in terms of status and material wealth, there was often a price to pay.

### ***The cost of conformity***

Doctors earn a helluva lot more by being a GP in the country [which] does give you access to a lot of things (AFSP3).

According to Rhodes (2001: 353), wives of high earning professionals who give primacy to their husband's occupation over their own gain certain benefits, not least 'financial security and a comfortable lifestyle'. This belief belies any negative consequences of their caregiving role on a woman's sense of wellbeing that may be compounded by cultural, social, professional and geographic isolation:

I feel very stifled. ... I also have the issue where most of my friends work so it is quite lonely (AFSP3).

Another spouse echoed her sense of isolation:

I was very much alone. I spoke to myself and said you are not getting in to a rut; get on with life. ... Sometimes I get angry with him because I am not a housewife. I kept it inside for some time and one day I blew (OFSP1).

One spouse, who was having difficulty coping with the encroachment of her husband's work on family life, accepted the situation resignedly:

I feel at a loss as to what can be done about it. It is [his] lifestyle choice. He wants to do what he wants to do and I want him to be happy and that is important. It is important for him to know what he wants out of life (AFSP1).

The effect on family life of male rural GPs' intense involvement in their practice revealed a spouse's sense of entitlement to her husband's time that was often thwarted by the demands of patients:

They want the best for their patients. But, just for once it would be nice if he came home early. I feel the disruption more now I have kids. Just for once it would be nice if we had a turn (OFSP3).

One older spouse reflected on the long-term consequences of her partner's passionate commitment to his work in her life:

Well, I sometimes think would it matter if I was here or not because he is so driven? He loves his job and the truth is that when he is at home he is burnt out, really switched off (AFSP3).

Her sense of disillusionment is evident as she competes with her partner's work for demands on his time where 'everything is legitimate because the patient is in need' (AFSP3). She reflected that his role as a GP offers him a 'legitimate place to listen and ask [patients] questions [where] you don't have to give of yourself'. The effect of this emotional disconnection became a way to avoid 'relating to me on an intimate level'. She commented that being a rural GP in private practice 'is a big price to pay in terms of relationships'.

Comments from women about the degree to which patients 'adored' (AFSP7) the GP who was a 'wonderful doctor' (AFSP4) and a 'wonderful man' (AFSP5) were not unusual. Yet, such comments reinforced the lesser value felt by spouses in the face of the important work carried out by their GP partner.

### ***Identity***

One spouse commented that her sense of identity was relatively invisible in relation to the esteem in which her husband was held in the community:

You really are a nobody. People are interested in you because you are the doctor's wife, not because of you as a person. ... I like being a doctor's wife, though, and hearing people speak highly of him. I feel proud of him (OFSP2).

The theme of being perceived by the community to have no separate identity outside that of a doctor's spouse is reflected in other comments:

I keep on being introduced as the doctor's wife whereas I am also a professional. It is the first time I have been introduced like that. ... It is just here that people don't know what I have done and where I come from. I am seen just as a full-time mum (OFSP3).

However, while being a GP's wife had benefits in terms of social status, material wealth and financial security, other disadvantages were also discussed in terms of perceived social and emotional costs. Some women felt they were 'under scrutiny' and 'living in a goldfish bowl' (OFSP6) with others feeling disillusioned at the loss of an identity separate from that of rural GP's spouse, a role which tended to usurp all others. In interactions with community residents one woman commented:

The only communication I have is about him, not about me. So I go somewhere and they tell me all about my husband. Nobody is really interested in me. It is like I am the appendage (laughs). If I don't agree that he is the most wonderful thing ever to be born, then we have no conversation. It is like I don't really exist; just a shadow I guess (AFSP7).

Nevertheless, women were often protective of their GP spouses' interests, despite the emotional consequences of his work on their relationship. Coming to terms with these consequences was not easy in a rural town where discussing anything negative about their partner was generally not considered an option. This choice often led to a sense of social isolation:

There wasn't any support. In country areas doctors' wives are separate. The doctor's wife feels different. If she talks about confidences to people it might get around town, and what you are saying comes back to the husband's reputation. So you can't really say a lot about what is going on in the marriage because it is his reputation at stake. So from that point of view you feel duty bound not to talk about things. The difficulty is that people come up to you in the street and say: "oh, he's such a wonderful doctor, such a lovely man" and you feel bad that you have a problem with him. So you can't really open up about those issues. [You have to be] loyal to your husband otherwise his whole name suffers in the town so you can't say anything (AFSP7).

Upholding the good name of their GP partner is also preferable from a business perspective:

I don't talk to anyone in the community because, from a business perspective I can't be putting down Adam ... because they all think he is fantastic (AFSP4).

Spouses also mentioned other social constraints on their behaviour as a result of expectations of their role as the spouse of the GP. Some women commented on the sense of responsibility they felt as the doctor's wife to 'be good and set an example' (OFSP6) to the local community 'like not drink when I am pregnant' (OFSP3) or even to 'dress properly' (OFSP8) and:

... look decent and put your lippie on to whiz down to the town because people know who you are (AFSP2).

One woman in a small rural town in an isolated area explained this behaviour in relation to living up to expectations in the community:

You never let down your guard. I never discuss personal issues with anyone. There's no escape. If you have a problem in these little places you wouldn't go to anyone because you are supposed to be perfect (OFSP8).

Many spouses went beyond the call of duty by supporting, and justifying, not only the GP's work but also his entitlement to leisure even if his relaxation pursuits did not include her or the children:

He plays sport all the time and he has to do that to relax. He is not really a lie around home sort of person (AFSP4).

Rather than challenge any inequity, many wives justified their choice as part of their role of being a good wife, which led one to comment bemusedly:

I don't think [me being low on the priority list] is intentional. But I have to say this about doctors, they have an incredible arrogance. It is as if, "well, I'm saving the world, I deserve to have this time to do my own thing when I have time off. This is important. I have got to do it". Like nothing else is as important (AFSP3).

One woman reflected on the possible outcome of spouses seeking to change their subordinate position by seriously questioning pervasive inequities in their relationship with their GP partner:

The financial issues are huge, absolutely huge. I know a couple of wives who stay there for the money, though they would probably never admit that. It is the lifestyle, the children at private school, nice clothes, going to the best hairdresser and not having to work (AFSP7).

This response suggests some of the material advantages in being a doctor's wife. It also implies that her social status reflects her partner's important role as the local GP in a rural community. Her position as his spouse also provides her with economic security and the promise of a comfortable lifestyle. However, she may subjugate any aspirations of her own to the primacy of supporting her GP partner. Challenging power inequities embedded in her relationship may destabilise her already vulnerable position, given her economic dependency on her partner. She may not be prepared or want to do that. Meeting and valuing her own needs requires that she recognise and wrestle with the importance of a 'self' as separate from her role as doctor's wife and negotiate how these needs can best be expressed. Not every spouse fitted the mould of the doctor's wife whose life and identity revolved around her GP spouse and family. A few were determined to meet their aspirations outside those of caregiver.

### ***Multiple femininities***

Some women, whilst supporting their husband's work, created and maintained an identity separate from that of rural GP's wife, which often caused tension. While opportunities to work locally in their chosen profession were often limited or non-existent, a reality that often led to frustration, one spouse spent many weeks every year travelling away from home to pursue her career. She had moved to a rural centre to support her husband's work and was reluctant to stay long-term:

I am not dying here. There is a time limit to how long I can stay here. Fine for my husband...but for me I have tried every possible way [to meet] people because I hate just sitting at home and doing housework because that is not my life. I get very frustrated and angry. He used to go to work and have things to tell me, but I had nothing to talk about. ... Nothing will make me want to stay here. There is nothing for me here. I want a purpose in life. Not the purpose of getting up and doing the housework and waiting for the husband to come home for

lunch. I would like to have [the choice] to do things. I will never belong here (OFSP1).

Most women in their role as the main caregiver were unwilling to subjugate their educational or occupational aspirations indefinitely. Some resented their partner's sense of entitlement when their own needs or identity, separate from those of 'doctor's wife,' were not honoured in their own right, often leading to tension in the marital relationship. Spouses 'fitted in' their work or study after they had met the needs of the GP and the family. One spouse had switched careers and given up the opportunity for post-graduate study by accommodating her partner's wishes and moving to a rural area:

I sort of resented that. I'm over it now and I couldn't go back. Well, I could but it would mean I would have to move to the city to do it. It's pretty hard to do external studies (AFSP4).

Few spouses had seriously considered the option that GPs, who 'work so hard' (AFSP3), might modify their work arrangements to enable their wives to work. Instead, women implied that there was little room to negotiate beyond their accommodating role, not least because 'he makes more money so it is obvious that he works and I look after the kids' (AFSP3). Any sense of inequity was over-ridden by rationalising the need to support the important work carried out by the GP. However, feelings of resentment surfaced when GPs were apparently unaware of their spouses' support:

He asked how I had been supporting him which made me very angry. I said that for him to have a balanced life, you have a family to come home to at night. And I have contributed to the practice, made a lot of suggestions. ...What I do doesn't feel valued (AFSP3).

Female spouses who did not conform to their prescribed roles were often marginalised. Should the marriage break down, the wife, rather than the institutional structure of rural general practice was more likely to be held to account. According to one male GP:

A lot of doctors want to come to country areas. Most doctors will go anywhere. It is their wives. It's always the same. If you want to come to the country you can't marry a city girl. It is just a no-no. It is really terrible. ... If your spouse is happy, you

can go anywhere. We have had so many spouses down here who have made their husbands' lives miserable and have either left or separated. Or they lead funny, separated lives where the wife stays with the children in Perth and the GP stays down here. A funny sort of existence (AMGP 11).

From this response, negative judgements ensue about rural GPs' spouses if they allow other priorities take precedence over their supportive role. For one woman who pursued her interests, conflict and isolation, rather than cooperation and understanding, were the outcomes:

My whole study experience was quite lonely. It was very much my thing where the family, even Simon, were not involved. I did [my study] in between the washing and the cooking and the bringing up the children. I didn't really feel supported by the family. They came first and if I got my study in, that was good. I think Simon saw it as a hobby, a nice little hobby. A little patronising really even though he knew it was important to me. There are days when I am very pissed off when I have said to Simon "I don't want to do this any more". I actually feel like I have sacrificed a lot of myself because of Simon's role. I get frustrated because I feel like I have got my wings clipped all the time (AFSP3).

This response reveals disillusionment with the inequity of existing gender relations where any needs spouses had outside the home were permissible only if they fitted in with the pre-existing organisational structure of the family. This participant noticed that, as the children became more demanding:

... he seemed to work a bit more. I think he sees [childcare] as another chore that he really doesn't want to do ... It is far more stimulating to go to work. ... Staying at work to finish all the paperwork and books is probably more relaxing (AFSP3).

This participant was aware of costs of such the inequities and felt resentful enough to consider leaving the marriage:

In a sense when you are married to a country GP you always come last. The priorities are amazing. In my circumstances I find it amazing what Simon will put before us and it causes problems and I have laid down some ultimatums and have been ready to go (AFSP3).

Another woman reflected that spouses of rural GPs wanting a life outside their supportive role was unrealistic at best:

Spouses often don't get a look in for their career. If their partner is happy in medicine, well, you accept that. That's all you really need. You wouldn't want icing on it. Just a nice cake will do very nicely (AFSP6).

### ***Downsizing career aspirations***

Most female spouses of rural GPs had professional backgrounds such as medical imaging, pharmacy, nursing and teaching, yet few currently worked in their profession and all were economically dependent on their husband/partner. This raises questions about the notion of professional under-achievement amongst this group of women. Institutional constraints conspired against some professional women who had trained overseas yet their qualifications and experience were not recognised in Australia. One highly qualified professional woman had worked for many years in her chosen field in her country of origin. Arriving in Australia she was confronted with obstacles that precluded early employment:

Coming here [the professional governing body] won't acknowledge my qualifications. It will take me five years to pretty much do whole training again. There is an exam in two stages. The first stage is two papers about all your pre-graduate work. You have to pass both papers before you can progress to stage two consisting of two thousand hours of practical work and assignments and going to Perth for courses. After that you take another exam and then they consider whether you are good enough to [practise]. I am not going to do it. It is just too much that they ask for that (OFSP4).

Added to this, opportunities in a rural area in her chosen field were limited. While she did not rule out the option of employment in the future, she had downsized her aspirations:

Eventually, if I find another job, I will do it. I actually thought of finding out if there is a technical college here and doing a secretarial course and do some job that is wanted here. They all want childcare (OFSP4).

Some younger female spouses who took responsibility for childcare hoped to find employment in their profession once their children were at school. One, who had given up her career to look after her husband and children, hoped her husband would reciprocate in future and support her:

We have put his career first, I suppose, and kids growing up to school age too. ... I would perhaps hope down the track that he would help me out. I know it would be reciprocal, when he could do it, because that is the sort of person he is (AFSP1).

Conforming to the role of caregiver, particularly for spouses with young children seemed to supersede any desire for current employment outside the home:

My main focus at the moment is [my children]. When they are at school, I would really like to work again. But I don't have any set idea. I don't want to work full-time...My responsibility is to look after our children on a day to day basis (AFSP2).

### ***Resistance to structural constraints***

While hegemonic beliefs about gender relations were played out in social practice, the importance attributed to the GP's position by rural communities further constrained spouses' choices to meet their needs outside their supportive role. One spouse suggested that the community 'doesn't set [GPs] up as a deity but does put them on a pedestal' (AFSP3) which led to GPs being 'full of themselves' where they like being 'top dog' (AFSP3). Some wives considered they were the GP's 'reality check' (AFSP3, AFSP4):

It is only through me pulling him up and being a dragon that he gets his perspective back again because I think he loses perspective. I actually think GPs have a very narrow perspective on life. There is no time, no breathing time. They have so many demands on them (AFSP3).

Rural GPs are expected to work long hours which 'really does encroach' (AFSP4) on their home life as the GP 'does not treat the family as sacrosanct [because] work takes precedence' (AFGP3). Most rural GPs were enthusiastic and passionate about their work, despite its demands and stresses, with one commenting he 'enjoyed every day' (AMGP7) in rural general practice. Their commitment to their work is reflected in their spouses' responses:

I think they think they are irreplaceable. [They think] "if I am not there, things will fall apart. People are relying on me to be there". No one is irreplaceable (AFSP2).

Spouses voiced their reservations about such commitment which one considered 'stupid' not least because 'your relationship suffers and I resent that' (AFSP4).

Others spouses pondered the consequences of long and demanding working hours should the GP become ill:

He will not take a day off sick. He has got to go into work.  
They think they are indispensable (AFSP7).

Another spouse from a small rural town in an isolated location imagined the reality of GPs not being indispensable:

What happens if something happens to [GP]. If she gets cleaned up in front of the house who the hell is going to fix her (AMSP1)?

One woman contested the 'noble' role of her GP partner by reflecting more deeply on the notion of power embedded in his position at work and in the community and its effects in the GP/spouse relationship. When asked about spouses subjugating their own interests to support those of their partner, she commented:

I believe [GPs] need to be needed and they will often become doctors because it is a very satisfying profession...but in the end, that feeds the ego. For a lot of them it is more than duty, ... it is being important and that goes on in their working life and patients adore them for it. At home they may not get that adoration. ... A lot of doctors have a lot of power. They might not be aware of it or be very nice with it but there is a lot of subtle power and they do need to be dominant. A lot of the doctors' wives have been submissive to the extent they will give up their career, travelling, anything they may want to do on their own and bow down to their husband's wishes because he is superior, because he does this wonderful work, and they can't actually match him (AFSP7).

Such comments offer an insight into the consequences of women's doxic acceptance of the imbalance of power in the marital relationship. Women who comply with traditional gender roles that give primacy to supporting their GP partners are often implicitly required to subjugate any aspirations that conflict with that role, despite its effect on their sense of well-being. One spouse considered the early days of her marriage:

My identity was completely tied up with his. I was part of the machine. I was too busy with the kids and I didn't know any better. I had never been exposed to [feminist] ideas. I had been

brought up in the work ethic where loyalty [was important] and [I had been] sheltered. There was nothing in me. Everything was for him. I can't explain that any better. I was numb maybe and it didn't reach me (AFSP7).

Many spouses continue to accept their subordinate role. However, some feel angry and frustrated that their GP partners gave so little consideration to their need to develop a sense of identity and autonomy separate from their role as GP's spouse:

I felt I was doing it all on my own but I always wanted a slice for myself which is what my study was about, otherwise you get snaffled up in this all consuming life of being the doctor's wife and making it happen for one person. I guess I was making a point. I am a person too. I squeezed it in. But that is what a lot of people do. I am not alone (AFSP3).

Expectations and experiences of male spouses of rural GPs revealed a different story.

### ***Male spouses***

Of the five male spouses I interviewed, all conformed to their role as provider by either working or looking for paid employment. There was a far greater acceptance in rural communities that male spouses will work outside the home, reinforcing conventional gender stereotypes. One male spouse had recently found full-time employment, one worked part-time, another ran his own business from home. Two were in the process of seeking employment. The hegemonic role of male as full-time provider was destabilised by variations in work practices such as role reversal and working part-time. Responses to those variations were mixed, revealing tensions underpinning the notion of multiple masculinities.

### ***Multiple masculinities***

One male spouse was well aware of the importance of GPs to rural areas, and commented wryly that, as a male spouse, the community expected him to work outside the home, unlike his female counterparts. He had reversed roles with his GP partner, happily worked part-time so she could fulfil her career aspirations as a full-time rural GP and he could have more time to pursue non-

work activities. Another male spouse had made the decision with his GP partner that they both work part-time, having run their own business for several years which involved long working hours. Moving to a rural area was a long-term, lifestyle choice where they planned to spend more leisure time together as a couple and as a family.

While some female spouses conformed to social expectations and gave up their careers to support their GP partner and family by taking on the caregiving role full-time, all male spouses either earned an income or were looking for employment on top of their caregiving role. They generally found work in their original career, occasionally modifying their work practices by working from home. One man expressed clearly the sacrifice he had made in giving up a 'bloody good job' to reverse roles so his wife could work full-time:

Margaret would never have been able to come here if I didn't have a job where I could work from home or was prepared to just give it all up and be at home (AMSP1).

He continued to manage his own business from home and help with her general practice. When asked whether the demands of Margaret's work encroached on family life, his comments played down her working hours when compared to the long hours he worked in his previous employment

A long day at work for Margaret is eight hours and a long day for me was 14-18 hours. ... Margaret comes home for lunch every day. I don't think I have ever had a lunch break that I can recall (AMSP1).

However, as Connell (1977) suggests, dominant ideas can be contested and changed. In the context of gender relations, expectations for male spouses to meet the role of main provider were offset by a counter-hegemonic belief in the importance of their role as caregiver:

I guess I underestimated how [the demands of Margaret's work] would affect having children. So I much prefer to spend time with the children than be at work. ... That time with children you can never get back. Friends with older children missed out on that because they were working too much (AMSP1).

However, other men found coming to terms with reversing roles more difficult despite their choice often being a temporary arrangement where there was ‘an end in sight’ (OMSP2). One spouse felt his sense of masculinity was compromised in the caregiving role which he did not consider ‘manly’ (OMSP2) and struggled not to withdraw socially and isolate himself from the community. Despite valuing the extra time being a caregiver gave him to spend with his children, he consoled himself with the knowledge that, ‘deep down, I knew I was a lawyer’. However, once he found full-time work his spouse reduced her hours to become the primary caregiver. One female GP considered that her husband’s sense of masculinity was compromised when he was without paid employment. She expressed her discomfort that her spouse had been unable to find work while she was employed full-time; she felt responsible for his predicament.

He is very clever. I am nothing. I am just a small doctor here to treat some people. He has so much knowledge. ... I would not have come to a [rural area] if I had known my husband getting work would be this difficult (OFGP1).

Participants’ responses indicated that dominant expectations for men to earn an income were strong and tied up with notions of masculinity, even though some men contested this position by reversing roles with their GP partner. Nonetheless, all men either provided economically for their families, or planned to, with none taking on full-time the role of caregiver.

The influence of structural factors on social practice is evident in rural GPs’ spouses’ responses to dominant expectations of gender relations where most conformed to conventional notions of masculinity and femininity with male as provider and female as primary caregiver. However, a dialectical relationship between structure and social practice was also revealed when some resisted such norms. Their resistance, while causing tension, had the potential to lead to change.

### **The future of rural general practice**

Examining the dialectical relationship between structural issues and social practice offers a broader perspective to view difficulties recruiting and retaining GPs and their spouses in rural locations and provides a more nuanced

analysis of the complexity of the issue. The effects of resistance to dominant expectations of the social practice of gender are seen in female spouses seeking employment outside the home, or male spouses reversing roles with their GP partner, both often leading to tension as different individuals and groups struggle to meet their respective interests that often conflict with the so-called norm. This struggle is set against a backdrop of political and economic changes where the effects of rural restructuring and development have also constrained spouses' choices to work outside the home particularly in locations where a range of services, educational or training opportunities have been withdrawn. For spouses of rural GPs wanting to further their careers or education and training, the effects of such structural influences need attention when considering recruitment and retention issues and planning future rural general practice services.

Interviews with male spouses of rural GPs indicated the power of structural influences on social practice giving credence to the view that notions of masculinity and the role of provider are powerfully entwined. Tension was evident in the discomfort felt by some male spouses who resisted such expectations by reversing roles with their GP partners to become the primary caregiver. However, all male spouses were employed or were looking for work outside their caregiving role. By making this choice, they were meeting social expectations of masculinity and conforming to their role as provider. In all cases, the decision to find paid employment was supported by their GP partners and the local community.

Dominant expectations of gender relations also influenced the social practice of female spouses of rural GPs who conformed to the role of primary caregiver. The exalted position the male GP holds in a rural community, the demands of his work and the prescribed need for a supportive 'wife' impacted on expectations of his spouse's role. Structural constraints on female spouses' choices sometimes caused tension as women who wanted to pursue other interests struggled to balance their individual needs with those of their role as primary caregiver. Such constraints often reinforced women's subordinate position by giving primacy to their caregiving role. Conforming to that role elicited approval and support in a social context.

Tensions were revealed in responses from women who contested their hegemonic role by seeking a sense of identity separate from that of 'doctor's wife'. The imbalance in power between the male rural GP and his female spouse often constrained the woman's sense of entitlement to seek fulfilment outside their role of 'doctor's wife', particularly if it conflicted with the work of the GP. Bourdieu's (2002) notion that women misrecognise the inequitable distribution of power in their relationships as a form of symbolic violence is evident in the responses of some female spouses. The pervasiveness in social practice of many women's doxic acceptance of their role as caregiver emerges when they legitimate its importance as part of the normal social order rather than acknowledge its oppressive nature. Indeed, the notion that 'if he's happy, I'm happy' reinforces a sense of identity that is dependent on, and merges with, that of their partner.

However, the price, it seems, of conformity is often the renunciation of a significant part of their identity or sense of self that is separate from that of doctor's wife. This was exacerbated when educational and employment opportunities were limited in rural towns. Despite this, Dempsey (1992) argues that, while there may be an underlying current of resistance from some spouses, few women seriously contest the prevailing social order and do not expect change either in the organisation of domestic labour or in their male partners. Indeed, legitimating the value of their caregiving role by subjugating any educational or occupational aspirations that compete with the GP's role as provider maintains their dependent position.

In other words, conforming to dominant gender practices and not questioning structural inequities embedded in dominant beliefs about gender relations effectively reproduces them. To seek to understand women's complicity in subordinating their aspirations outside their caregiving role requires acknowledging the effects on their identity or sense of 'self' of misrecognising the symbolic violence that treats their needs and aspirations outside dominant expectations of their role as inferior. By reflecting on the effects of such inequities, women can consider what they may stand to lose, or gain, if they contest such expectations. Despite their own needs often being treated as inferior, their work devalued and their aspirations limited, responses suggest that

reproducing hegemonic practices seems preferable to the alternative which may extract too great a cost on female spouses' social and economic wellbeing particularly if they have become deskilled or have downsized their educational and occupational aspirations.

However, some women want changes so that expectations outside their role as caregiver are met and valued. Currently, meeting their own educational or occupational needs is an important factor affecting their sense of well being. The process of doing so, however, is often difficult and is generally contingent on giving primacy to their caregiving role. Nevertheless, the hopes of those women with expectations and aspirations beyond that role are important when considering issues related to recruiting and retaining GPs and their families to live and work in rural locations.

## Conclusion

This project was first formulated by working on a problem identified by the Great Southern Division of General Practice (GSDGP), namely the difficulty in recruiting and retaining GPs in rural locations. The area covered by the GSDGP includes the well-resourced, large rural centre of Albany, medium sized centres with fewer resources but populations large enough to support one or more group practices, and small rural centres where medical services are provided by a solo GP. Small rural centres are often located at considerable distance from larger centres. GPs practising medicine in rural areas face not only professional difficulties associated with working in settings limited in resources and support, but they and their spouses also meet social and sometimes cultural challenges that affect their decisions to live and work in a rural location.

Recruiting and retraining rural GPs is not a newly identified problem. The problem has been at the centre of research, lobbying and policy for some decades, and it was not clear initially what could be added by yet another study. There were, however, a number of common elements in previous studies. They were mainly focused on the GP, and on family members only in so far as they were 'variables' in explaining problems faced by GPs. Studies often centred on expectations and experiences of GPs intersecting with the perceived disadvantages of living and working in a rural environment. In addition, there were a number of matters where previous research revealed little acknowledgment or critique which this study showed to be important such as assumptions regarding the gendered division of labour. Many studies have also worked within the paradigm which put medical practice and doctors at the centre in rural health service delivery. Given the reluctance of Australian trained medical graduates to move to the country, health policies have opened the door to recruiting increasing numbers of OTDs as a temporary solution to provide services in rural settings while still maintaining a medico-centric focus. However, in locations unable to attract doctors, senior registered nurses have provided health care but as a 'second best' option. The radical changes to medical practice wrought by neoliberal policies are another factor warranting

examination in the context of recruiting and retaining rural GPs. Such policies are simultaneously committed to market deregulation and the demand for accountability in areas where it is not possible for markets to exercise discipline over practitioners. Health budgets have been declining or growing less rapidly at the same time as bureaucratic requirements for accountability have been increasing. For all kinds of reasons, this mix makes living and working more difficult in rural areas than in urban areas

This thesis expands the parameters within which to view the problem of recruiting and retaining GPs in rural centres. It locates the discourse within a broader social context by critically examining the effects of structural influences such as gender relations and the political and economic climate on the everyday expectations and experiences of rural GPs and their spouses. Findings show that approaching the issue this way offers a more complex, nuanced understanding of factors influencing GPs and their spouses to stay or leave rural locations. Examining the dialectical relationship between structural factors and social practice provides a framework in which to more deeply analyse the issue.

The disadvantages faced by GPs living and working in a rural environment are well documented. While a rural setting cannot always meet the professional and lifestyle expectations of GPs and their spouses, keeping the debate centred on the needs of individual GPs and their families, or the disadvantages of rural 'space', works against critically examining the issue within a broader social context. Opening up the discourse to identify the effects of structural issues on social practice expands the parameters within which to view the problem and consider innovative solutions.

Despite recent social changes impacting on rural general practice and the perceived disadvantages of living in a rural location, findings from this study showed that most rural GPs interviewed had no intention of moving to a city to work. They experienced enormous satisfaction working as rural GPs, particularly if they practised procedural medicine such as obstetrics, anaesthetics, surgery or emergency medicine. Most felt fulfilled professionally, enjoyed the variety of work and the opportunity to practise continuity of care with their patients 'from the cradle to the grave'. Many were proud to be rural GPs and rural general

practice had been their first career choice. The majority of those interviewed espoused a male model of rural general practice involving long working hours.

Nonetheless, political and economic changes are affecting rural GPs' enjoyment of their work. Increasing government regulation in clinical practice and demands for more accountability for their work practices has diminished their sense of autonomy and control often leading to a sense of frustration. While such changes affect both rural and urban GPs, rural GPs are also faced with the negative effects of restructuring and development that have resulted in diminishing populations and a withdrawal of services in some rural areas making them less attractive places to work.

The expectations and experiences of rural GPs' spouses are also important when considering recruitment and retention but their social, cultural, occupational, educational or training needs have often been relegated backstage in terms of importance. This study has foregrounded the spouse's role in decisions to live and/or work in a rural location noting differences in expectations and experiences between male and female spouses. Findings highlighted the significance of structural influences on social practice particularly in the area of gender relations.

Some male spouses of rural GPs, while resisting dominant expectations by becoming the caregiver, also work in paid employment. Choosing to work part-time to support their GP partner frees them up to care for their children and/or to pursue leisure interests. Effectively, they are opening the door to expressing multiple masculinities that go beyond meeting hegemonic expectations of their role as provider. Most female spouses conform to dominant expectations of their role as primary caregiver. In the process they gain social approval, financial security and social status. Findings also revealed that the cost of such conformity for some female spouses of rural GPs is the subjugation of their sense of a 'self' as separate from that of wife and mother. Spouses are likely to become deskilled in their profession or occupation and are often financially dependent on their GP partner. Those who do pursue occupational or educational interests outside the home often attend to the demands of their caregiving role first or fit in their other interests around their caregiving role. However, as a

result of political and economic changes, services have been withdrawn in some rural locations thereby limiting opportunities for spouses of rural GPs wanting employment, particularly if childcare services are not available, making the probability of recruiting GPs to work in those areas less likely.

Few women in this study challenge hegemonic expectations of their role in the home. All female rural GPs are either married or in committed relationships and all but one have children. Many find it more practicable to change expectations of medical practice than to change the relationships between mothers, fathers and children. For female rural GPs with children, none question the centrality of their roles as wife and mother in their lives. Their identity as caregiver generally takes precedence over their role as doctor where, according to one female rural GP, 'most women doctors would say their core identity is as wife and mother and GP would be third' (AFGP5). Their choice to work fewer hours is often predicated on meeting the expectations of their caregiving role in the home. These findings support research in Australia and Britain that women and men's expectations of gender relations continue to fall along conventional lines. Findings from Dempsey's research on gender relations in a rural context support these conclusions.

Critically examining women's 'doxic' acceptance of the primacy of their caregiving role evokes the notion of symbolic violence embedded in the inequitable power imbalance in gender relations. Actions that subordinate the needs of women constitute 'symbolic violence' when they hide power relations at a structural level that limit women's choices at the level of social practice. This occurs without direct or overt coercion but as a result of women internalising their subordinate position as part of the normal social order (See Connelly & Healey, 2004: 15). Very few women challenge their role as the primary caregiver in the home. Those who do question inequities in the power balance in the division of labour and who are not earning an income risk losing their social and economic status should their circumstances alter. Generally, female spouses meet their occupational or educational aspirations by 'fitting them in' around their caregiving role. If such aspirations conflict with their caregiving responsibilities and cause tension with their partners, some female spouses withstand the tension and persist in meeting needs that honour their sense of 'self' as separate from that

of doctor's wife. In doing so they act as agents for change and indicate the existence of multiple femininities that resist not only the assumptions embedded in their caregiving role, but also its potentially oppressive nature.

The organisational structure of rural general practice has long supported a male model of work practice despite increasing numbers of women entering medicine and training as rural GPs. However a deeper analysis of the relationship between structural elements and social practice in this context is warranted in light of planning rural GP services in future. This study broadens the focus of previous research by examining the issue in relation to gender role expectations in both medical and rural contexts. While women may resist dominant expectations of work patterns in rural general practice by adopting a more flexible approach to working hours, findings show that compliance is contextual and not automatically transferred across settings. Agreeing to dominant expectations in one context may require resisting them in another. In order to meet expectations of their role as caregiver in the home, some female rural GPs require more flexible hours in the workplace, causing frustration amongst some of their male colleagues. Embedded within the notion of a dialectical relationship between structural influences and social practice is the potential for change that emerges from the tension generated as opposing views meet. The propensity of younger male rural GPs in this study, consistent with others of their generation, is to want a better balance between work and other aspects of life. Some younger male rural GPs support the reduction in long working hours as a way to balance work and other pursuits. Research from Britain reveals that older GPs also want change to their work patterns where they work fewer hours in order to attain more balance in their lives (Young et al., 2001).

Recruiting OTDs as a temporary solution to the shortage of doctors in rural areas is not without problems. Training more doctors in Australia with a view to filling those vacancies in the long-term assumes local graduates will want to work in rural areas but evidence has shown this is not the case. Filling those positions with doctors trained overseas has created an uneasy relationship between medical professionals. Recently arrived OTDs are accepted as 'good enough' in those rural areas unable to attract their Australian trained colleagues, but not otherwise despite their experience and expertise. This study has

addressed factors specifically affecting the professional and social integration of doctors trained overseas and their spouses and sought to understand whether the expectations they bring to Australia are adequately fulfilled in a rural location. OTDs from different cultural and linguistic backgrounds live and work in a variety of rural locations in Australia. Findings from this study indicate commonalities between OTDs and their spouses in expectations of life in Australia but also a diversity of experiences in rural general practice. Opportunities for their families and a better and safer lifestyle are big drawcards. Cultural dislocation, isolation and limited job opportunities for spouses in their chosen field are challenges to the integration process. Warm welcomes and acceptance by local communities help to offset feelings of loneliness.

In a political and economic climate where competition is encouraged, other health professions vie with GPs to offer health services that were previously the prerogative only of the medical profession. Some GPs see this development as inevitable. Many accept health professionals providing services in rural settings unable to attract GPs as long as the medical profession maintains its dominant role in rural health care. By effectively reproducing the dominant status of the medical profession, rural GPs implicitly regard the services other health professions offer as having less value. Uneasy relationships between medical and other health professionals are created where senior registered nurses or nurse practitioners are considered 'good enough' if there are no doctors available, but not otherwise.

What this study has done is allow rural GPs and spouses to express their ideas, thoughts, opinions, beliefs, expectations and experiences and open up questions in a space created by the ethnographic researcher. From this, it is possible to conclude that if we do not resolve the problems generated by:

- a) an organisational structure supporting a male model of rural general practice in a climate where nearly 60 per cent of medical students are now women,

- b) the desire amongst female and some male rural GPs for more flexible work practices to attain a balance between work and home,

c) the reluctance of locally trained medical graduates to work in the country,

d) the decision to provide more medical school places as a long-term solution to the rural recruitment and retention problem that is affected by a section of the Australian Constitution that prohibits any form of ‘civil conscription’ of medical practitioners to work in areas of need,

e) viewing OTDs as a short-term solution,

f) current political and economic restructuring and development of rural communities often leading to services being withdrawn, reduced employment, education and training and diminishing populations making the choice to work in some rural locations less attractive,

g) limited occupational, educational and training opportunities for spouses,

h) a medico-centric approach to rural health care making implementing innovative solutions outside that paradigm more difficult,

then we are not going to resolve the problems of recruitment and retention of GPs in rural areas. Not only must we be prepared to recast the problem in terms other than medico-centric ones if we are to meet the need for comprehensive and innovative rural health care, but we must also acknowledge the significance of the matters set out above. This is what this study has done.

The study has also raised various issues that are beyond the capacity of this thesis to explore but nevertheless indicate scope for further research, such as the following:

a) the impact on rural medical workforce planning of an ageing male rural GP workforce whose work practices involve long hours, growing numbers of women entering medicine who, along with some male GPs, want flexible working hours, and spouses of rural GPs who want to continue their careers,

c) marriages/relationships in which rural GPs and their partners are in full-time employment and the division of labour in the home is negotiated equitably,

d) underutilisation of spouses' skills in areas where employment opportunities in their chosen field are limited,

e) increased focus on viewing rural health care from a perspective that examines broader social issues that determine health such as the effects of unemployment,

f) the effects of diversity between rural communities when planning health care provision,

g) increasing the role of health professionals such as senior registered nurses/nurse practitioners and Aboriginal health workers in rural health care,

h) the effect of neoliberalist principles on changing the culture of rural health care.

The broader implications for anthropology and sociology from the findings of this study are also evident in various contexts. According to Bell (1978: 37), the notion of 'studying up' is important and 'sociology's attention should, for a while at least, be focused on the powerful and the consequences of their power on us all'. This perspective has influenced a critical examination of:

a) the position of the medical profession in the social organisation of rural health care and factors underpinning professional relationships between rural GPs and other health professionals in the current political and economic climate

b) expectations of gender relations in a professional context between male and female rural GPs,

c) expectations of gender relations in rural medical marriages and factors underpinning many female spouses' doxic acceptance of their primary caregiving role.

Such an approach opens the door to critically examining similarities and differences in other professional or elite groups such as dentists, lawyers or accountants in rural contexts and comparing them with similar groups in urban settings.

## References

- Abbot, T. (2004). *Budget 2004-2005 Health 1-6*. Canberra: Commonwealth Department of Health and Ageing.
- a'Brook, M. (1990). Psychosis and depression. *The Practitioner*, 234(November), 992-993.
- Access Economics. (2002). *An analysis of the widening gap between community need and the availability of GP services*. Canberra: Australian Medical Association.
- Alexander, J. (2000). The changing role of clinicians in Australia and New Zealand. In A. Bloom (Ed.), *Health reform in Australia and New Zealand* (pp. 161-182). Oxford: Oxford University Press.
- Alston, M. (2005). Gender perspectives in Australian rural community life. In C. Cocklin & J. Dibden (Eds.), *Sustainability and change in rural Australia* (pp. 139-156). Sydney: University of New South Wales Press.
- Altheide, D., & Johnson, J. (1994). Criteria for assessing interpretive validity in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 485-499). Thousand Oaks: Sage.
- Argent, N., & Rolley, F. (2000). Lopping the branches: Bank branch closure and rural Australian communities. In B. Pritchard & F. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 140-168). Sydney: University of New South Wales.
- Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248-261). Thousand Oaks, California: Sage.
- Australian Department of Health and Ageing. (2005). *Review of the rural, remote and metropolitan areas (RRMA) classification. Discussion paper*. Canberra: Australian Department of Health and Ageing.
- Australian Government Budget. (2003). *Australian Government budget rural health initiatives*. Retrieved March 10, 2004, from <http://www.ruralhealth.gov.au/policy/budget.htm>
- Australian Government Department of Health and Ageing. (2003). *Workforce support for rural general practitioners*. Retrieved March 10, 2004, from <http://www.ruralhealth.gov.au/workers/wsrp.htm>
- Australian Government Department of Health and Ageing. (2004). *Medicare Plus*. Retrieved September 17, 2004, from <http://www.health.gov.au/medicareplus/about/factsheets/fact09.htm>
- Australian Government Department of Health and Ageing. (2005). *General practice in Australia: 2004*. Canberra: Australian Government: Department of Health and Ageing.
- Australian Health Care Agreement Reference Groups. (2002). *A report to the Australian Health Ministers' conference from Australian Health Care*

- Agreement Reference Groups*. Canberra: Commonwealth Department of Health and Ageing.
- Australian Institute of Health and Welfare. (1999a). *Medical labour force 1997: National Health Labour Force Series* (No. HWL-13). Canberra: AIHW.
- Australian Institute of Health and Welfare. (1999b). *Medical labour force 1999: Labour Force Series* (No. HWL-24). Canberra: AIHW.
- Australian Institute of Health and Welfare. (2000). *Australia's health 2000*. Canberra: AIHW.
- Australian Institute of Health and Welfare. (2002). *Australia's health 2002: The eighth biennial report of the Australian Institute of Health and Welfare (AIHW)*. Canberra: AIHW.
- Australian Medical Association. (1994). *AMA position statements: Nurse practitioner statement*. Canberra: AMA.
- Australian Medical Association. (2001a). *AMA submission to the Commonwealth review of the impact of the Trade Practices Act (1974) on the recruitment and retention of rural doctors*. Canberra, ACT: AMA.
- Australian Medical Association. (2001b). *Geographic allocation of Medicare provider numbers: Position statement*. Canberra: Australian Medical Association.
- Australian Medical Workforce Advisory Committee. (1998). *Influences in participation in the Australian medical workforce* (No. 1998.4). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (1999). *Temporary resident doctors in Australia: Distribution, characteristics and role* (No. 1999.3). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2000). *The general practice workforce in Australia: Supply and requirements 1999-2010* (No. 2000.2). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2003). *Career decision making by doctors in vocational training: AMWAC medical careers survey 2002*. Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2004a). *Annual Report 2003-2004* (No. 2004.5). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2004b). *Survey of doctors working in rural and remote locations under Australia's five-year overseas trained doctor recruitment scheme: Report to the national review steering committee of the five year overseas trained doctor scheme*. Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee. (2005). *The general practice workforce in Australia: Supply and requirements to 2013* (No. 2005.2). Sydney: AMWAC.

- Australian Medical Workforce Advisory Committee, & Australian Institute of Health and Welfare. (1996). *Australian medical workforce benchmarks* (No. 1996.1). Sydney: AMWAC.
- Australian Medical Workforce Advisory Committee, & Australian Institute of Health and Welfare. (1998). *Medical workforce supply and demand in Australia: A discussion paper* (No. AMWAC 1998.8, AIHW No. HWL12). Sydney: AMWAC, AIHW.
- Australian Rural and Remote Workforce Agencies Group. (2003-2004). *Annual report*. Canberra: Commonwealth Department of Health and Ageing.
- Australian Rural and Remote Workforce Agencies Group. (2004). *Overseas trained doctors and the rural and remote workforce: Policy position paper 2*. Canberra: Commonwealth Department of Health and Ageing.
- Baer, H. (1982). On the political economy of health. *Medical Anthropology Newsletter*, 14(1), 1-2, 13-17.
- Baer, H., Singer, M., & Johnsen, J. (1986). Towards a critical medical anthropology. *Social Science and Medicine*, 23(2), 95-98.
- Bates, T. (2002). Gramsci and the theory of hegemony. In J. Martin (Ed.), *Antonio Gramsci: Critical assessments of leading political philosophers* (pp. 245-262). London: Routledge.
- Battin, T. (1991). What is this thing called economic rationalism? *Australian Journal of Social Issues*, 26(4), 294-307.
- Baxter, J., & Western, M. (1998). Satisfaction with housework: Examining the paradox. *Sociology*, 32(1), 101-121.
- Beagan, B. (2001). Neutralising differences: Producing neutral doctors for (almost) neutral patients. *Social Science & Medicine*, 51, 1253-1265.
- Beeson, M., & Firth, A. (1998). Neoliberalism as a political rationality. *Journal of Sociology*, 34(3), 215-231.
- Bell, C. (1978). Studying the locally powerful. In C. Bell & S. Encel (Eds.), *Inside the whale: ten personal accounts of social research* (pp. 14-40). Sydney: Pergamon Press.
- Benjamin, O. (1998). Therapeutic discourse, power and change: emotion and negotiation in marital conversations. *Sociology*, 32(4), 771.
- Bernard. (1982). *The future of marriage*. New Haven: Yale University Press.
- Birrell, B. (1995). Immigration and the surplus of doctors in Australia. *People and Place*, 3(3), 23-31.
- Birrell, B. (1997). Hunger strikes and the accreditation of overseas trained doctors in Australia. *People and Place*, 5(4), 53-58.
- Birrell, B. (2001). Doctor dilemmas: How GP medicine is practised in Australia. *People and Place*, 9(3), 41-53.
- Birrell, B., & Hawthorne, L. (2004). Medicare Plus and overseas trained medical doctors. *People and Place*, 12(2), 84-100.

- Bittman, M., Hoffman, S., & Thompson, D. (2004). *Men's uptake of family-friendly employment provisions* (No. Policy Research Paper Number 22). Canberra: Australian Government Department of Family and Community Services.
- Black, A. (2005). Rural communities and sustainability. In C. Cocklin & J. Dibden (Eds.), *Sustainability and change in rural Australia* (pp. 20-37). Sydney: University of New South Wales Press.
- Black, A., Duff, J., Saggars, S., Baines, P., Jennings, A., & Bowen, P. (2000). *Rural communities and rural social issues: Priorities for research* (No. ECU-4A). Canberra: Rural Industries Research and Development Commission.
- Boffa, J. (2002). Is there a doctor in the house? *Australian and New Zealand Journal of Public Health*, 26(4), 301-304.
- Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory*, 7(1), 14-25.
- Bourdieu, P. (2004). *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Bourdieu, P., & Passeron, J.-C. (1977). *Reproduction in education, society and culture*. London: Sage.
- Bourdieu, P., & Wacquant, L. (2002). *An invitation to reflexive sociology*. Cambridge: Polity.
- Brines, J. (1994). Economic dependency, gender and the division of labor at home. *American Journal of Sociology*, 100(3), 652-688.
- Bryant, L. (1997, n.d.). *The voice of women in medicine*. Paper presented at the Royal Australian College of General Practitioners Conference, Hobart, Tasmania.
- Burns, R. (1997). *Introduction to research methods* (3rd ed.). Melbourne: Addison Wesley Longman.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. London: Routledge.
- Butler, J. (1993). *Bodies that matter: On the discursive limits of sex*. London: Routledge.
- Calnan, M., & Williams, S. (1995). Challenges to professional autonomy in the United Kingdom? The perceptions of general practitioners. *International Journal of Health Services*, 25(2), 219-241.
- Carson, D., & Stringer, K. (1998, August 27-28). *Generation and gender issues: The emerging culture within the rural and remote medical workforce: Cultures in caring*. Paper presented at the 4th Biennial Australian Rural and Remote Health Scientific Conference, Empire Theatre, Toowoomba, Queensland.
- Chernichovsky, D. (1995). Health system reforms in industrialised democracies: an emerging paradigm. *The Milbank Quarterly*, 73(3), 339-372.

- Chesters, J., Han, G.-S., Strasser, S., & Ballis, H. (2001). Doctoring rural towns. In J. Dibden, M. Fletcher & C. Cocklin (Eds.), *All change! Gippsland perspectives on regional Australia in transition: Occasional Papers* (pp. 71-78). Melbourne: Monash University.
- Christians, C. (2000). Ethics and politics in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 133-155). Thousand Oaks, California: Sage.
- Clearihan, L. (1999). Feminisation of the medical workforce. *Australian Family Physician*, 28(6), 529.
- Cocklin, C., & Alston, M. (Eds.). (2003). *Community sustainability in rural Australia: A question of capital?* Wagga Wagga NSW: Charles Sturt University.
- Commonwealth Department of Health and Ageing Divisions of General Practice Program. (2002). *Guidelines for the workforce support for rural general practitioners program under the Divisions of General Practice program*. Canberra: Commonwealth Department of Health and Ageing.
- Connell, R. W. (1977). *Ruling class, ruling culture: Studies of conflict, power and hegemony in Australian life*. Cambridge: Cambridge University Press.
- Connell, R. W. (1987). *Gender and power*. Sydney: Allen and Unwin.
- Connell, R. W. (1995). *Masculinities*. Sydney: Allen and Unwin.
- Connell, R. W. (2002). *Gender*. Cambridge: Polity.
- Connelly, P., & Healey, J. (2004). Symbolic violence, locality and social class: The educational and career aspirations of 10-11-year-old boys in Belfast. *Pedagogy, Culture and Society*, 12(1), 15-33.
- Conochie, I. (1990). Denmark: An outline history. Denmark, WA: Denmark Tourist Bureau.
- Crompton, R., & Le Feuvre, N. (2003). Continuity and change in the gender segregation of the medical profession in Britain and France. *International Journal of Sociology and Social Policy*, 23(4), 36-58.
- Cutchin, M. (1997). Physician retention in rural communities: The perspective of experiential place integration. *Health and Place*, 3(1), 25-41.
- Danziger, S. (1979). On doctor watching: Fieldwork in medical settings. *Urban Life*, 7(4), 513-532.
- Davies, C. (1996). The sociology of professions and the profession of gender. *Sociology*, 30(4), 661-679.
- Davis, A. (1993). Economising health. In S. Rees, G. Rodley & F. Stilwell (Eds.), *Beyond the market: Alternatives to economic rationalism* (pp. 119-135). Sydney: Pluto Press.
- Day, C. (2000). *Municipal heritage inventory review for the City of Albany*. Perth: Heritage Today.

- De Laine, M. (1997). *Ethnography: theory and applications in health research*. Sydney: MacLennan and Petty.
- de Vaus, D. (1997). Family values in the nineties. *Family Matters*, 48(Spring/Summer), 5-10.
- Delane, M. (2002, 22-24 April). *Help for WA medical families only a phone call away*. Paper presented at the Australian Rural and Remote Workforce Agencies (ARRWAG) Conference, Adelaide.
- Delphy, C. (1992). A theory of marriage. In L. McDowell & R. Pringle (Eds.), *Defining women: Social institutions and gender divisions* (pp. 138-140). Cambridge: Polity Press.
- Delphy, C., & Leonard, D. (1992). *Familiar exploitation: A new analysis of marriage in contemporary Western societies*. Cambridge: Polity Press.
- Dempsey, K. (1990). *Smalltown: A study in social inequality, cohesion and belonging*. Melbourne: Oxford university Press.
- Dempsey, K. (1992). *A man's town: Inequality between women and men in rural Australia*. Oxford: Oxford University Press.
- Dempsey, K. (1997a). *Inequalities in marriage: Australia and beyond*. Melbourne: Oxford University Press.
- Dempsey, K. (1997b). Women's perceptions of fairness and the persistence of an unequal division of housework. *Family Matters*, 48(Spring/Summer), 15 - 19.
- Dempsey, K. (1999). Attempting to explain women's perceptions of the fairness of the division of housework. *Journal of Family Studies*, 51(1), 3-24.
- Department of Health, W. A. (2003). *The country health services review: The way forward for country health services in Western Australia*. Perth: Department of Health, WA.
- Department of Primary Industries and Energy, & Department of Human Services and Health. (1994). *Rural, remote and metropolitan areas classification 1991 census edition*. Canberra: Commonwealth of Australia.
- Donovan, H. (2003). *Australian/State/Northern Territory national review. The five year overseas trained doctor recruitment scheme: The Western Australian perspective*. Perth: Department of Health, Government of Western Australia.
- Duckett, S. (2004). *The Australian health care system* (2nd. ed.). Oxford: Oxford University Press.
- Duff, J. (2001). Financing to foster community health care: A comparative analysis of Singapore, Europe, North America and Australia. *Current Sociology*, 49(3), 135-154.
- Duff, J., Larsen, A.-C., Tonts, M., & Ainsworth, F. (2000). *Entrepreneurialism in the service professions: The delivery of services in a competitive, market-driven global economy*. Perth, Western Australia: Edith Cowan University.

- Easton, B. (1997). *The commercialisation of New Zealand*. Auckland: Auckland University Press.
- Elston, M. (1991). The politics of professional power: Medicine in a changing health service. In J. Gabe, M. Calnan & M. Bury (Eds.), *The sociology of the health service* (pp. 58-88). London: Routledge.
- Elston, M. (1993). Women doctors in a changing profession: the case of Britain. In E. Riska & K. Wegar (Eds.), *Gender, work and medicine: Women and the medical division of labour* (pp. 27-61). London: Sage.
- Emerson, R., Fretz, R., & Shaw, L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- Encel, S. (1978). In search of power. In C. Bell & S. Encel (Eds.), *Inside the whale: Ten personal accounts of social research* (pp. 41-66). Sydney: Pergamon Press.
- Eve, R., & Hodgkin, P. (1997). Professionalism and medicine. In J. Broadbent, M. Dietrich & J. Roberts (Eds.), *The end of the professions? The restructuring of professional work*. (pp. 69-85). London: Routledge.
- Fagan, R., & Webber, M. (1995). *Global restructuring: The Australian experience*. Oxford: Oxford University Press.
- Feldman, M., Bell, J., & Berger, M. (Eds.). (2003). *Gaining access: A practical and theoretical guide for qualitative researchers*. Walnut Creek, Ca.: Alta Mira Press.
- Femia, J. (2002). Hegemony and consciousness in the thought of Antonio Gramsci. In J. Martin (Ed.), *Antonio Gramsci: Critical assessments of leading political philosophers* (pp. 263-286). London: Routledge.
- Finch, J. (1983). *Married to the job: Wives' incorporation in men's work*. London: George, Allen and Unwin.
- Fleming, J., McRae, C., & Tegen, S. (2001, March 4-7). *From the ground up - successful models of community capacity building to address recruitment and retention of GPs in rural South Australia*. Paper presented at the 6th National Rural Health Conference, Canberra.
- Forgacs, D. (Ed.). (1988). *A Gramsci reader: Selected writings 1916-1935*. London: Lawrence and Wishart.
- Fowlkes, M. (1980). *Behind every successful man: Wives of medicine and academe*. New York: Columbia University Press.
- Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd, Mead and Company.
- Frost, C. (2002, 9-13 June). *General Practice: What, where, when, why and how the experience could be improved. A summary report*. Paper presented at the WONCA Europe, ESGP/FM Conference, London, UK.
- Gabbard, G., Menninger, R., & Coyne, L. (1987). Sources of conflict in the medical marriage. *American Journal of Psychiatry*, 144(5), 567-572.
- Game, A., & Pringle, R. (1983). *Gender at work*. Sydney: George, Allen and Unwin.

- Garden, D. (1977). *Albany: A panorama of the Sound from 1827*. Melbourne: Nelson.
- General Practice Strategic Policy Development Unit. (2000). *General practice in Australia 2000*. Canberra: Australian Government Department of Health and Ageing.
- Germov, J. (2003a). Challenges to medical dominance. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (2nd ed., pp. 283-305). Melbourne: Oxford University Press.
- Germov, J. (2003b). Imagining health problems as social issues. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (pp. 3-27). Melbourne: Oxford University Press.
- Giddens, A. (1986). *The constitution of society*. Berkeley: University of California Press.
- Gramsci, A. (1999). *Selections from the prison notebooks* (Q. Hoare & G. N. Smith, Trans.). New York: International Publishers.
- Gray, I., & Lawrence, G. (2001). *A future for regional Australia: Escaping global misfortune*. Cambridge: Cambridge University Press.
- Great Southern Development Commission. (2003). *Great Southern economic perspective: An update on the economy of Western Australia's Great Southern region*. Perth, WA: Department of Local Government and Regional Development.
- Green, J. (1993). The views of single-handed general practitioners: A qualitative study. *British Medical Journal*, 307(6904), 607-611.
- Hafferty, F., & Light, D. (1995). Professional dynamics and the changing nature of medical work. *Journal of Health and Social Behaviour*, 36, 132-153.
- Hakim, C. (1995). Five feminist myths about women's employment. *British Journal of Sociology*, 4(3), 428-455.
- Hakim, C. (2003a). Competing family models, competing social policies. *Family Matters*, 64(Autumn), 52-61.
- Hakim, C. (2003b). *Models of the family in modern societies: Ideals and realities*. Aldershot, Hants: Ashgate.
- Hall Yandoli, A. (1989). Stress and medical marriages. *Stress Medicine*, 5, 213-219.
- Halliday, J., & Little, J. (2001). Amongst women: Exploring the reality of rural childcare. *Sociologica Ruralis*, 41(4), 423-436.
- Hamilton, C. (2001). Putting doctors where they are needed. *The Australian Institute Newsletter*, 27.
- Hamilton, C. (2003). *Growth fetish*. Sydney: Allen and Unwin.
- Hammersley, M. (1990). *Reading ethnographic research: A critical guide*. London: Longman.
- Hammersley, M. (1992). *What's wrong with ethnography?* London: Routledge.

- Hammersley, M., & Atkinson, P. (1995). *Ethnography; principles in practice* (2nd ed.). London: Routledge.
- Hand, K., & Lewis, V. (2002). Fathers' views on family life and paid work. *Family Matters*, 61(Autumn), 26-29.
- Haslam McKenzie, F. (2000). Where do people fit in the rural equation? In B. Pritchard & P. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 73-89). Sydney: University of New South Wales.
- Hawthorne, L., & Birrell, B. (2002). Doctor shortages and their impact on the quality of medical care in Australia. *People and Place*, 10(3), 55-67.
- Hays, R. (1999). Common international themes in rural medicine. *Australian Journal of Rural Health*, 7, 191-194.
- Hays, R., Wynd, S., Veitch, C., & Crossland, L. (2003). Getting the balance right? GPs who choose to stay in rural practice. *Australian Journal of Rural Health*, 11, 193-198.
- Hegney, D., & McCarthy, A. (2002). Preparation for rural nursing practice. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 237-252). Melbourne: Oxford University Press.
- Hindess, B. (1998). Neoliberalism and the national economy. In M. Dean & B. Hindess (Eds.), *Governing Australia* (pp. 210-226). Cambridge: Cambridge University Press.
- Hirsch, N., & Fredericks, C. (2001, 4-7 March). *Rural doctors and retention*. Paper presented at the 6th National Rural Health Conference, Canberra.
- Hochschild, A. (1989). *The second shift: Working parents and the revolution at home*. New York: Viking.
- Hochschild, A. (2003). *The commercialization of intimate life: Notes from home and work*. Berkeley, California: University of California Press.
- Holub, L., & Williams, B. (1996). The general practice Rural Incentives Program, development and implementation: Progress to date. *Australian Journal of Rural Health*, 4, 117-127.
- Humphreys, J. (1985). A political economy approach to the allocation of health care resources: The case of remote areas of Queensland. *Australian Geography Studies*, 23(2), 222-242.
- Humphreys, J. (1998). Delimiting 'rural': implications of an agreed rurality index for healthcare planning and resource allocation. *Australian Journal of Rural Health*, 6(4), 212-216.
- Humphreys, J., Jones, J., Jones, M., Hugo, G., Bamford, E., & Taylor, D. (2001). A critical review of rural medical workforce retention in Australia. *Australian Health Review*, 24(4), 91-102.
- Humphreys, J., & Rolley, F. (1998). A modified framework for rural general practice: The importance of recruitment and retention. *Social Science and Medicine*, 46(8), 939-945.

- Incitti, F., Rourke, L., Rourke, J., & Kennard, M. (2003). Rural women family physicians: Are they unique? *Canadian Family Physician*, 49(March), 320-327.
- Jenkins, R. (1993). *Pierre Bourdieu*. London: Routledge.
- Johnson, L. (1989). The guns of King George's Sound: The Albany forts. Albany, WA: Albany Advertiser.
- Johnson, L. (2001). *Albany: Who and what?* Albany, WA: Western Australian Museum.
- Jones, J. A., Humphreys, J. S., & Adena, M. (2004). Doctors' perspectives on the viability of rural practice. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*, 4(online)(305).
- Joyce, C., McNeil, J., & Stoelwinder, U. (2004). Time for a new approach to medical workforce planning. *Medical Journal of Australia*, 180(7), 343-346.
- Kamien, M. (1987). *Report of the ministerial inquiry into the recruitment and retention of country doctors in Western Australia*. Perth: University of Western Australia.
- Kamien, M. (1998). Staying in or leaving rural practice: 1996 outcomes of doctors' 1986 intentions. *Medical Journal of Australia*, 169, 318-321.
- Keleher, H. (1999). Rural public health matters. *Australia and New Zealand Journal of Public Health*, 23(4), 242-245.
- Keyzer, D. (1997). Working together: The advanced rural nurse practitioner and the rural doctor. *Australian Journal of Rural Health*, 5, 184-189.
- Kilmartin, M., Newell, C., & Line, M. (2002). The balancing act: Key issues in the lives of women general practitioners in Australia. *Medical Journal of Australia*, 177(15 July), 87-89.
- Komter, A. (1989). Hidden power in marriage. *Gender and Society*, 3(2), 187-216.
- Krais, B. (1993). Gender and symbolic violence: Female oppression in the light of Pierre Bourdieu's theory of social practice. In C. Calhoun, E. LiPuma & M. Postone (Eds.), *Bourdieu: Critical perspectives* (pp. 156-177). Cambridge: Polity.
- Kuhlmann, E. (2002, 2-4 May). *Post-modern times for professions: Theoretical issues and empirical evidence from the field of health care*. Paper presented at the Research Network Sociology of Professions in the ESA, Second Interim Workshop, Paris.
- Lapeyre, N. (2003). Professional and domestic work arrangements of women general practitioners in France. *International Journal of Sociology and Health Policy*, 23(4/5), 97-122.
- Larson, A. (2002). Contemporary rural Australian society. In D. Wilkinson & I. Blue (Eds.), *The New Rural Health* (pp. 3-11). Oxford: OUP.
- Latham, M. (1994). A third way: Beyond incremental reform of the Australian health economy. *Australian Health Review*, 17(4), 34-62.

- Laven, G., & Wilkinson, D. (2003). Rural doctors and rural backgrounds: How strong is the evidence? A systematic review. *Australian Journal of Rural Health, 11*, 277-284.
- Lawrance, R. (2001, 4-7 March). *What symbolises rural and remote general practice: The practitioners' perspective*. Paper presented at the Sixth National Rural Health Conference, Canberra, ACT.
- Lechte, J. (1996). *Fifty key contemporary thinkers: From structuralism to postmodernity*. London: Routledge.
- Leese, B., & Young, R. (1999). *Disappearing GPs: Is there a crisis in recruitment and retention of general practitioners in England?*. Manchester: National Primary Care Research and Development Centre.
- Lippert, N. (1991, 14-16 February). *The spouses: A major support for the rural doctor*. Paper presented at the First National Rural Health Conference, Toowoomba, Queensland.
- Lippert, N., & Tolhurst, H. (2001, September). *Female rural GPs: Findings of the National Female Rural GP Research Project*. Paper presented at the 44th RACGP Scientific Convention, Sydney.
- Little, J. (1997). Employment marginality and women's self-identity. In P. Cloke & J. Little (Eds.), *Contested countryside cultures: Otherness, marginalisation and rurality* (pp. 138-157). London: Routledge.
- Lockie, S. (2000). Crisis and conflict: shifting discourses or rural and regional Australia. In B. Pritchard & P. McManus (Eds.), *Land of discontent: The dynamics of change in rural and regional Australia* (pp. 14-32). Sydney: University of New South Wales.
- Lupton, D. (2000). *Medicine as culture: Illness, disease and the body in Western societies*. London: Sage.
- Lyle, D. (2002). Infrastructure and support for rural practitioners. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 260-272). Oxford: Oxford University Press.
- MacIsaac, P., Snowden, T., Thompson, R., Crossland, L., & Veitch, C. (2000). General practitioners leaving rural practice in Western Victoria. *Australian Journal of Rural Health, 8*, 68-72.
- MacKinnon, C. (1997). Feminism, Marxism, method and state. In D. Tietjens Myers (Ed.), *Feminist social thought: A reader* (pp. 64-92). New York: Routledge.
- Maginn, P. (forthcoming). Negotiating and securing access: Reflections on an ethnographic study into urban regeneration, community power and 'race' in the UK.
- Maher, L. (2001). Rural Retention. *GP Review, 5*(10), online. Retrieved June 5, 2004, from <http://www.racgp.org.au/document.asp?id=4196>
- Maushart, S. (2001). *Wifework: What marriage really means for women*. Melbourne: The Text Publishing Company.

- McAvoy, B. (2000-2001). Models of primary health care: The UK experience. *New Doctor*(74, summer), 9-12.
- McKenzie, F. (2003). Regional skills shortages: An overview of demographic, economic and social change. *Sustaining Regions*, 3(1), 5-15.
- McKevitt, C., & Morgan, M. (1997). Anomalous patients: The experiences of doctors with an illness. *Sociology of Health and Illness*, 19(5), 644-667.
- McKinlay, J. B., & Arches, J. (1985). Towards the proletarianization of physicians. *International Journal of Health Services*, 15, 161-195.
- McKinlay, J. B., & Marceau, L. (2002). The end of the golden age of doctoring. *International Journal of Health Services*, 32(2), 379-416.
- McMahon, A. (1998). Blokus domesticus: The sensitive new age guy in Australia. *Journal of Australian Studies*, 56, 147-157.
- Melleuish, G. (1997). Living in an age of packages: "Economic rationalism" and "the clever country" in Australian political thought. *Australian Journal of Politics and History*, 43(2), 200-213.
- Miles, J., Krell, R., & Tsung-Yi, L. (1975). The doctor's wife: Mental illness and marital pattern. *International Journal of Psychiatry in Medicine*, 6(4), 481-487.
- Miles, R., Marshall, C., Rolfe, J., & Noonan, S. (2004, February 19). *The attraction and retention of professionals to regional areas*. Paper presented at the Bureau of Transport and Regional Economics Inaugural National Regional Research Colloquium, Canberra.
- Mills, I. (1997). Recruiting general practitioners to rural areas: One community's experience. *Australian Journal of Rural Health*, 5, 194-197.
- Murphy, R. (1971). *The dialectics of social life: Alarms and excursions in anthropological theory*. London: Basic Books Inc.
- Nader, L. (1972). Up the anthropologist: Perspectives gained from studying up. In D. Hymes (Ed.), *Reinventing anthropology* (pp. 284-311). New York: Pantheon.
- National Rural Health Alliance. (2004). PARTYline goes to the polls. *PARTYline: National Rural Health Alliance Inc*, May, 10-11. Retrieved July 23, 2004, from <http://www.ruralhealth.org.au/nrhpublic/Index.cfm?Category=PartyLine>
- National Rural Health Policy Forum, & National Rural Health Alliance. (1999-2003). *Healthy horizons*. Canberra: Department of Health and Aged Care, Australian Health Ministers Conference.
- Nelson, S. (1978). Some dynamics of medical marriages. *Journal of the Royal College of General Practitioners*, 28, 585-586.
- Nichols, A. (1997, 9-12 February.). *The spouses of rural doctors: A significant influence on professional life in the bush*. Paper presented at the 4th National Rural Health Conference, Perth, Western Australia.

- Nord, E., Richardson, J., Street, A., Kuhse, H., & Singer, P. (1995). Maximizing health benefits vs egalitarianism: An Australian survey of health issues. *Social Science & Medicine*, 41(10), 1429-1437.
- Oakley, A. (1985). *The sociology of housework*. Oxford: Basil Blackwell.
- O'Reilly, M. (1997). Medical recruitment in rural Canada: Marathon breaks cycle. *Canadian Medical Association Journal*, 156(11), 1593-1596.
- Ortner, S. (1989). *High religion: A cultural and political history of Sherpa Buddhism*. Princeton: Princeton University Press.
- Palmer, G., & Short, S. (2000). *Health care and public policy: An Australian analysis* (3rd ed.). Melbourne: Macmillan.
- Pearson, A. (1993, 12-14 February). *Expansion and extension of rural health workers' roles to increase access to health services in rural areas*. Paper presented at the 2nd National Rural Health Conference, University of New England, Armidale, NSW.
- Peck, J., & Tickell, A. (1994). Jungle law breaks out: Neoliberalism and global-local disorder. *Area*, 26(4), 317-326.
- Phelps, K. (2002). *AMA President, Media Conference, Canberra*. Retrieved March 16, 2004, from <http://www.ama.com.au/web.nsf/doc/SHED-5EXHQV>
- Phillips, A. (2005). *Rural, regional and remote health: Indicators of health*. Canberra: Australian Institute of Health and Welfare.
- Pringle, R. (1997). Feminist theory and the world of the social. *Current Sociology*, 45(2), 1-6.
- Pringle, R. (1998). *Sex and medicine: Gender, power and authority in the medical profession*. Cambridge: Cambridge University Press.
- Rabinowitz, H., Diamond, J., Hojat, M., & Hazelwood, C. (1999). Demographic, educational and economic factors related to the recruitment and retention of physicians in rural Pennsylvania. *Journal of Rural Health*, 15(2), 212-218.
- Rees, S. (1994). Economic rationalism: An ideology of exclusion. *Australian Journal of Social Issues*, 29(2), 171-185.
- Rhodes, L. (2001). *Two for the price of one: A qualitative study of the lives of mining wives*. Unpublished PhD thesis, Curtin University of Technology, Perth, Western Australia.
- Rice, P., & Ezzy, D. (2001). *Qualitative research methods: A health focus*. Oxford: Oxford University Press.
- Richards, A., Carley, J., Jenkins-Clarke, S., & Richards, D. A. (2000). Skill mix between nurses and doctors working in primary care-delegation or allocation: A review of the literature. *International Journal of Nursing Studies*, 37, 185-197.
- Riska, E., & Weagar, K. (1993). Women physicians: A new force in medicine? In E. Riska & W. K (Eds.), *Gender, work and medicine: Women and the medical division of labour* (pp. 77-94). London: Sage.

- Roach, S. (2002). *Female general practitioners in remote and rural Western Australia*. Perth: Western Australian Centre for Remote and Rural Medicine.
- Roach, S. (2003). *Overseas trained doctors: The WACRRM program 1999-2002*. Perth: Western Australian Centre for Rural and Remote Medicine (WACRRM).
- Rodger, J. (2000). *From a welfare state to a welfare society: The changing context of social policy in a postmodern era*. London: Macmillan's Press Ltd.
- Rural Doctors' Association of Australia. (2003a). *Geographic provider numbers*. Retrieved June 10, 2004, from <http://www.rdaa.com.au/default.cfm?action=publications>
- Rural Doctors' Association of Australia. (2003b). *Viable models for rural and remote practice: stage 1 and stage 2 report*. Canberra: RDAA.
- Sakinofsky, I. (1980). Suicide in doctors and wives of doctors. *Canadian Family Physician*, 26(June), 837-844.
- Sarantakos, S. (1998). *Social research*. Melbourne: Macmillan Education.
- Scholte, B. (1972). Toward a reflexive and critical anthropology. In D. Hymes (Ed.), *Reinventing anthropology* (pp. 430-458). New York: Pantheon.
- Scott, M., Whelan, A., Dewdney, J., & Zwi, A. (2004). "Brain drain" or ethical recruitment? Solving health workforce shortages with professionals from developing countries. *Medical Journal of Australia*, 180, 174-176.
- Sevier, K. (1990). *Spouse discussion group*. Paper presented at the Rural Doctors' Association Second Annual Conference, Coff's Harbour, NSW.
- Sexton, R. (2002, 22-24 April). *The Dr. DOC program: A South Australian rural GP health and wellbeing initiative of the Rural Doctors' Workforce Agency, South Australia*. Paper presented at the Australian Rural and Remote Workforce Agencies (ARRWAG) Conference, Adelaide.
- Shaffir, W., & Stebbins, R. (Eds.). (1991). *Experiencing fieldwork: An inside view of qualitative research*. London: Sage.
- Sibbald, B., & Young, R. (2001). *The general practitioner workforce 2000. Workload, job satisfaction, recruitment and retention*. Manchester: National Primary Research and Development Centre, University of Manchester.
- Siegloff, L. (1995). The nurse practitioner project, Wilcannia: Moving from anecdotes to evidence. *Australian Journal of Rural Health*, 3, 114-121.
- Simon, R. (1982). *Gramsci's political thought: An introduction*. London: Lawrence and Wishart.
- Singer, M. (1990). Reinventing medical anthropology: Toward a critical realignment. *Social Science and Medicine*, 30(2), 179-187.
- Singer, M., & Baer, H. (1995). *Critical medical anthropology*. Amityville, New York: Baywood Publishing Co Inc.

- Smailes, P. (1995). The enigma of sustainability of rural Australia. *Australian Geographer*, 26(2), 140-150.
- SMEC Australia Pty. Ltd. (2002). *Ravensthorpe/Esperance and Jerramungup strategic blueprint for the future*. Perth, WA: SMEC Australia Pty. Ltd.
- Smith, K., Humphreys, J., Lenard, Y., Jones, J., Prince, V., & Han, G.-S. (2004). Still the doctor - by a country mile! Preferences for health services in two country towns in north-west New South Wales. *Medical Journal of Australia*, 181(2), 91-95.
- Snadden, D. (1993). Leaving practice: General practitioners who decide to leave their practice. How to do it. *British Medical Journal*, 306(6894), 1740-1743.
- South West People Care. (2002). Shire of Jerramungup, (Draft 2) Strategic Plan 2002-2007. Busselton, WA: South West People Care.
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rhinehart, Winston.
- Steil, J. (1997). *Marital equality; its relationship to the wellbeing of husbands and wives*. Thousand Oaks: Sage.
- Strasser, R., Hays, R., Kamien, M., & Carson, D. (2000). Is Australian rural practice changing? Findings from the national rural general practice study. *Australian Journal of Rural Health*, 8, 222-226.
- Strasser, R., Kamien, M., & Hays, R. (1997). *National rural general practice study* (No. GPEP 465). Melbourne: Monash University, Centre for Rural Health.
- Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, California: Sage.
- Strong, K., Trickett, P., Titulaer, I., & Bhatia, K. (1998). *Health in rural and remote Australia* (No. PHE 6). Canberra: AIHW.
- Sullivan, O. (2000). The division of domestic labour: Twenty years of change? *Sociology*, 34(3), 437-456.
- Summers, A. (2003). *The end of equality: Work, babies and women's choices in 21st century Australia*. Sydney: Random House.
- Sutherland, V., & Cooper, C. (1992). Job stress, satisfaction and mental health among general practitioners before and after the introduction of new contract. *British Medical Journal*, 304(6841), 1545-1549.
- Tavris, C. (1992). *The mismeasure of woman*. New York: Simon and Schuster.
- Tedlock, B. (2000). Ethnography and ethnographic representation. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 455-486). Thousand Oaks, California: Sage.
- Tichenor, V. (1999). Status and income as gendered resources: The case of marital power. *Journal of Marriage and the Family*, 61(3), 638-650.

- Tonts, M. (2000). The restructuring of Australia's rural communities. In B. Pritchard & F. McManus (Eds.), *Land of discontent: the dynamics of change in rural and regional Australia* (pp. 52-72). Sydney: University New South Wales.
- Tonts, M. (2004). Spatially uneven development: Government policy and rural reform in the Wheatbelt of Western Australia. *Anthropological Forum*, 14(3), 237-252.
- Turner, B. (1997). From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. In A. Petersen & R. Bunton (Eds.), *Foucault: Health and medicine* (pp. vix-xxi). London: Routledge.
- Twaddle, A. (1996). Health system reforms: Toward a frame for international comparison. *Social Science and Medicine*, 43(5), 637-654.
- Van den Berg, R. (2002). *Nyoongar people of Australia*. Leiden: Brill.
- Van der Weyden, M. (2001). Australian general practice at a fork in the road: Which way forward? *Medical Journal of Australia*, 175, 62-63.
- Van Maanen, J. (1988). *Tales of the field: On writing ethnography*. Chicago: University of Chicago Press.
- Veitch, C., Harte, J., Hays, R., Pashen, D., & Clark, S. (1999). Community participation in the recruitment and retention of rural doctors: Methodological and logistical considerations. *Australian Journal of Rural Health*, 7, 206-211.
- Wainer, J. (2000). Women and rural medical practice. *South African Family Practice Journal*, 22(6), 19-23.
- Wainer, J. (2001). *Victorian rural women practitioner survey*. Melbourne: Rural Workforce Agency of Victoria.
- Wainer, J. (2002). *New voices in rural medical practice: Analysis of qualitative data from the national rural general practice study*. Melbourne and Canberra: Monash University, Commonwealth Department of Health and Ageing.
- Wainer, J. (2003). Gender and the medical curriculum: A rural case study. *Women and Health*, 37(4), 67-87.
- Wainer, J. (2004). Work of female rural doctors. *Australian Journal of Rural Health*, 12, 49-53.
- Wainer, J., Bryant, L., & Strasser, R. (2001). Sustainable rural practice for female general practitioners. *Australian Journal of Rural Health*, 9 (suppl.), S43-S48.
- Wainer, J., Bryant, L., Strasser, R., Carson, D., & Stringer, K. (1999, 14-17 March). *A life, not a wife*. Paper presented at the 5th National Rural Health Conference, Adelaide, South Australia.
- Wainer, J., Strasser, R., & Bryant, L. (2005, 10-13 March). *Strengthening the rural medical workforce: Understanding gender*. Paper presented at the 8th National Rural Health Conference, Alice Springs, Northern Territory.

- Walker, S. (1963). *History of hospital services in Albany, WA*. Albany, WA: Albany Public Library and Information Service: Local Studies Collection.
- Wearne, S., & Wakerman, J. (2004). Editorial: Training our future rural medical workforce. *Medical Journal of Australia*, 180, 101-102.
- Webb, J., Schirato, T., & Danaher, G. (2002). *Understanding Bourdieu*. Sydney: Allen and Unwin.
- West, C., & Zimmerman, D. (1987). Doing gender. *Gender and Society*, 1(2), 125-151.
- Western Australian Centre for Remote and Rural Medicine. (2003). *WACRRM annual review*. Perth: University of Western Australia.
- White, C., & Fergusson, S. (2001). *Discussion paper: Female medical practitioners in rural and remote Queensland: An analysis of findings, issues and trends*. Brisbane: Queensland Rural Medical Support Agency.
- White, K. (2000a). The state, the market and general practice: The Australian case. *International Journal of Health Services*, 30(2), 285-308.
- White, K. (2000b). What's happening in general practice: Capitalist monopolisation and state administrative control: a profession bailing out? *Annual Review of Health Social Sciences*, 10(1), 5-18.
- White, K. (2002). *An introduction to the sociology of health and illness*. London: Sage.
- Wicks, D. (2002). Nursing and sociology. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (2nd ed., pp. 306-324). Melbourne: Oxford University Press.
- Williams, R. (1994). Selections from Marxism and literature. In N. Dirks, G. Eley & S. Ortner (Eds.), *Culture, power and history: A reader in contemporary social theory* (pp. 585-608). Princeton: Princeton University Press.
- Willis, E. (1989). *Medical dominance* (revised ed.). Sydney: Allen and Unwin.
- Winefield, H. (2003). Work stress and its effects in general practitioners. In M. Dollard, A. Winefield & H. Winefield (Eds.), *Occupational stress in the service professions* (pp. 191-212). London: Taylor and Francis.
- Wise, A., Nichols, A., Chater, A., & Craig, M. (1996). *Rural doctors' spouses: Married to the practice?* Brisbane: Queensland Medical Education Centre.
- Witz, A. (1992). *Professions and patriarchy*. London: Routledge.
- Wolcott, H. (2001). *Writing up qualitative research* (2nd ed.). Thousand Oaks: Sage.
- Worley, P. (2004). Always one doctor away from a crisis! *Rural and Remote Health (online)*, 4(317), 1-3.
- Yalom, M. (2001). *A history of the wife*. London: Pandora.

Young, R., Leese, B., & Sibbald, B. (2001). Imbalances in the GP labour market in the UK: Evidence from a postal survey and interviews with GP leavers. *Work, Employment and Society*, 15(4), 699-719.

## Appendix 1a

Dr  
Chair,  
GSDGP

Dear Dr \_\_\_\_\_,

**Re: Study of factors affecting the wellbeing of GPs and their families in rural and remote WA**

You may recall that we met at the dinner following the GSDGP Continuing Professional Development day in November last year. I am happy to report that we are moving closer towards the data gathering phase. I wonder if I could take you up on your offer to read through and comment on the attached documents which I hope to send out to all GPs and their spouses/partners in the GSDGP inviting them to participate in the study. It would be helpful if I can enclose a letter from you. With this in mind, I have taken the liberty of drafting a letter for your consideration and possible amendment which I would be grateful if you would sign and return to me or drop it off with Mary MacNish at the Division.

I look forward to hearing from you.

Many thanks

Sincerely,

Angela Durey  
PhD Candidate  
Centre for Social Research  
Ph 08 6304 5162  
Email: [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

Chair

Great Southern Division of General Practice

Dear Colleagues and Spouses/Partners,

**Re: Study of factors affecting the wellbeing of GPs and their families  
in rural and remote WA**

Some of you might recall the Professional Development day in November 2002 where Angela Durey, a PhD candidate from the Centre for Social Research at Edith Cowan University, presented a proposal for her research on the above topic focusing on GPs and their families in the GSDGP. This is a project that has the support of the Australian Research Council, Edith Cowan University and The Great Southern Division of General Practice. Given the current relevance of issues related to the recruitment and retention of GPs and their families in rural and remote areas, I would encourage you and your partners/spouses to support this study by participating in the project.

Further information about the study and relevant contact details are attached.

Yours Sincerely

Dr \_\_\_\_\_

Chair

GSDGP

## **Appendix 1b**

### **Study of the wellbeing of rural GPs and their families**

Dear

I am writing to invite you to participate in an important research project that is supported by the Australian Research Council (ARC), Edith Cowan University (ECU), and the Great Southern Division of General Practice (GSDGP).

#### **Why is this study important?**

Some studies over the years have examined factors affecting recruitment and retention of GPs in rural and remote Australia. Recommendations have been suggested, some have been implemented, yet problems persist. This project is designed to cover areas not part of previous studies, including the responses and experiences of both GPs and their spouses/partners, a broader range of issues underpinning wellbeing and the decision to stay or leave rural practice in rural WA, and the impact of changes in government policy and community expectations. It is hoped this approach will provide a deeper understanding of issues affecting the recruitment and retention of rural GPs and their families with a view to creating some innovative solutions to the problems.

#### **Why is your help needed?**

The success of this research depends on your participation. It is hoped that insights generated from the project will inform the development of health policies and strategies aimed at improving health care provision generally in rural and remote communities. Results of the study may be shared with GPs and their spouses/partners involved in the project, though access to personal data will not be available to anyone other than myself so your confidentiality is assured. You will not be identified in any report resulting from this study.

#### **What next?**

This letter is being sent to all GPs and their spouses/partners in the GSDGP and a selected number who have worked or are currently working in a rural or remote area. I have attached an information sheet to introduce myself and explain what is involved. If you have any questions or would like further information, please feel free to either phone or email me. I will contact you again by phone in the hope that you will agree to participate in this important project at a time and place that is convenient to you.

Sincerely,

Angela Durey  
Centre for Social Research  
Ph : 08 6304 5162  
GSDGP  
08 9842 2797  
Email: [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

## Appendix 1c

### Information Sheet

Edith Cowan University (ECU) and the Great Southern Division of General Practice (GSDGP) are collaborating in research to identify issues related to the wellbeing of GPs and their spouses/partners living and working in rural and remote areas. The project aims to address problems associated with the diminishing number of GPs and how that affects health care provision in rural communities. The research will help the GSDGP to contribute to the debate and formation of public policy in issues related to rural health. This will include suggesting strategies to attract and retain GPs and their families to live and work in rural and remote areas and to improve the quality of health and medical services available in these locations.

Previous studies have shown that declining medical services in these areas have often led to GPs feeling overworked, stressed and frustrated at the demands placed on them and the effects of these on family life and leisure time. Spouses/partners also experience the effects of these demands along with, often, heightened community expectations of being the doctor's spouse. This proposed research is the first of its kind to be undertaken in Australia involving both GPs and their spouses/partners. It acknowledges the significant role that spouses/partners may play in the decision for the family to remain in or leave a rural community. It also seeks to understand the challenges you both face and the extent to which you think these problems can be improved including examining possible innovative solutions.

I am a PhD candidate at Edith Cowan University. This research will form part of my final dissertation. I hope at least 20 GPs and their spouses/partners will agree to participate. The project will involve my spending some time with you and your spouse/partner in the community in which you live to find out about the challenges, difficulties and positive aspects of living and working in a rural or remote area. This will include conducting interviews with each of you on your experiences in this context and their effects on your sense of wellbeing and your desire to stay or leave. In order to gain a depth of understanding of your experiences and to offer you the opportunity to speak about them and your views on issues related to the project, the interviews may last up to 2 hours. Where this is not possible, you may prefer to conduct a series of shorter interviews. I will do my best to fit in with what is most convenient for you. Topics for discussion will include the relationship between the demands of work on home life, the experiences of doctors and their families at different life stages or with different prior knowledge of rural life in Western Australia, the experiences and expectations of overseas trained doctors and their families and the impact on rural general practice of changes in government policy and community expectations.

I hope you'll enjoy taking part in the research and find it interesting. If you have any queries about the project or would like to discuss related concerns, please contact Angela Durey at ECU on 08 6304 5162, the Division on 08 9842 2797 or email [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au). If you have any unresolved concerns, please contact Associate Professor Sherry Sagers, Director, Centre for Social Research, Edith Cowan University, Joondalup, WA 6027 Phone 08 6304 5074 who is independent from the research team.

Thank you. Your assistance is much appreciated.

## Appendix 2a

GSDGP Newsletter article August 2003

### Study of the wellbeing of rural GPs and their families

This important research project is supported by the Australian Research Council, Edith Cowan University, and the Great Southern Division of General Practice. Various studies over the years have examined factors affecting recruitment and retention of GPs in rural and remote Australia. Recommendations have been suggested, some have been implemented, yet problems persist.

Declining medical services in these areas have often led to GPs feeling overworked, stressed and frustrated at the demands placed on them and the effects of those demands on their own health, family life and leisure time. Spouses/partners also experience the effects of these demands along with, often, heightened community expectations of being the doctor's spouse.

This project is designed to acknowledge these effects and to cover areas not part of previous studies, including the responses and experiences of both GPs and their spouses/partners, a broader range of issues underpinning wellbeing and the decision to stay or leave rural practice in rural WA, and the impact of changes in government policy and community expectations.

The project aims to address problems associated with the diminishing number of GPs and how that affects health care provision in rural communities. It is hoped this approach will provide a deeper understanding of issues affecting the recruitment and retention of rural GPs and their families with a view to improving the situation and creating some innovative solutions to the problems.

#### What is involved?

The success of this research depends on the participation of GPs and their spouses/partners in the GSDGP. The research will be conducted by Angela Durey, a PhD candidate at the Centre for Social Research, Edith Cowan University who lived in a rural area in the UK and Australia for many years as the spouse of a GP and has four grown up children. She originally trained as a State Registered Nurse in the UK, has an Honours degree in Anthropology and a Masters degree in Applied Anthropology. She will spend several months in the Great Southern from July and will contact all GPs and their spouses/partners in the region inviting them to participate in the project.

Part of her research will involve conducting interviews with GPs and their spouses/partners that will include topics relating to their experiences living and working in a rural or remote area, its effects on a sense of wellbeing and factors influencing the desire to stay or leave rural practice. It is hoped that insights generated from the project will inform the development of health policies and strategies aimed at improving health care provision generally in rural and remote communities.

For more information please contact Angela Durey 08 6304 5162 or 08 9842 2797 (from end of July) or email [a.durey@ecu.edu.au](mailto:a.durey@ecu.edu.au)

## GSDGP Newsletter article November 2005

I recently spent several months in the GSDGP travelling around the region as part of my PhD project. My aim was to meet and interview interested GPs and spouses/partners on factors affecting their wellbeing living and working in rural areas. Initial contact was made by sending information explaining the project to all GPs and their spouses/partners in the Division which was followed up by visits to every general practice in the GSDGP to arrange interviews with those interested in being involved. I contacted spouses/partners mainly through the GPs as accessing private phone numbers was difficult given confidentiality issues. I interviewed 21 spouses and 32 GPs (about 48% including registrars) with some agreeing to be interviewed twice and three times.

I am currently in the process of collating and analysing the information gathered. First impressions suggest the need to problematise the notion of 'rural' to adequately reflect the diversity inherent in the term by dividing 'rural' into regional centre, large rural centre with several GPs in group practices and small rural town serviced by solo GPs. This will help provide a framework to understand some of the factors affecting wellbeing of GPs and spouses living in these areas. Another impression from the interviews is that, while it may be difficult to recruit GPs to work in rural areas, retention seemed less of a problem with the majority of GPs and their spouses enjoying living in the country with plans to remain there rather than return to the city.

I would like to take this opportunity to thank everyone involved in the project for the time that you gave and your willingness to be interviewed. It was a pleasure to meet you and the depth and candour with which you shared your experiences, ideas, thoughts and comments were much appreciated. I look forward to collating and analysing the information which will extend the current debate on issues related to recruitment and retention of GPs and their families in rural areas.

## Appendix 3

### Consent form

Title of Project: A sociological study of the factors affecting the wellbeing of general practitioners and their spouses in rural and remote WA

Researcher

*Angela Durey, PhD Candidate, Centre for Social Research, School of International Cultural and Community Studies Faculty of Community Services, Education and Social Sciences, Edith Cowan University, Joondalup, Western Australia 6027*

I.....have read the information on the Information Sheet and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity realising that I may withdraw at any time.

I understand that all information provided is treated as strictly confidential and will not be released by the researcher unless required to do so by law.

I agree that research data gathered for this study may be published provided my name or other identifying information is not used.

I agree that the researcher can audio-tape this interview on the understanding that, following the completion of the project, including the submission of subsequent papers for publication, the data on the tape are deleted and transcripts and other records of interviews, destroyed

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

For further information or questions, please contact Angela Durey, ph 08 6304 5162. If you have any unresolved concerns please contact Associate Professor Sherry Saggars, Director, Centre for Social Research, Edith Cowan University, Joondalup, WA 6027. Ph 6304 5074 who is independent from the research team.

